MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH
BUREAU OF SUBSTANCE ABUSE SERVICES

MASSACHUSETTS
STRATEGIC PREVENTION ENHANCEMENT PROJECT

FINAL

COMPREHENSIVE 5-YEAR
STRATEGIC PREVENTION PLAN

JULY 27, 2012

TABLE OF CONTENTS

ADDITIONAL SUPPLEMENTAL DOCUMENTS

- **MASSACHUSETTS SUBSTANCE ABUSE EPIDEMIOLOGIC PROFILE: 2012 UPDATE**

- **MASSACHUSETTS STRATEGIC PREVENTION ENHANCEMENT PROJECT:**

  CAPACITY BUILDING/ INFRASTRUCTURE ENHANCEMENT PLAN

- **MASSACHUSETTS SUBSTANCE ABUSE AND MENTAL HEALTH CONCERNS:**

  NATIVE AMERICAN INDIANS AND MILITARY FAMILIES & VETERANS

- **MassCALL2 PROGRAM HIGHLIGHT: OPIOID OVERDOSE PREVENTION STRATEGIES**

Massachusetts Strategic Prevention Enhancement (SPE) Plan

OVERVIEW

The purpose of the ***Massachusetts Strategic Prevention Enhancement (SPE) Project*** was to execute a planning process to support more strategic, comprehensive systems of community-oriented care around statewide substance abuse prevention – with particular attention to communities of high need, such as Native American and military family populations. The process concentrated on building on current infrastructure and enhancing capacity, both statewide and at the community level. The prevention planning activities conducted via this SPE project were consistent with and relevant to three of the eight focus areas of the Commonwealth of Massachusetts Substance Abuse Strategic Plan Update (2010). These overlapping aims call for: maximizing interagency collaboration; identifying and addressing disparities throughout the service system; and increasing the capacity of communities and other service systems to prevent substance use and addictions while strengthening linkages to needed services.[1] This report details the processes, findings and strategic directions that evolved from this process. The resultant data-informed, outcomes-based ***Comprehensive Strategic Prevention Plan*** will guide the prevention activities of MA's Department of Public Health (MDPH)'s Bureau of Substance Abuse Services (BSAS) as we strive to augment substance abuse surveillance, streamline inter-agency and inter-departmental programmatic and resource coordination, as well as improve design and delivery of sustainable, culturally sensitive prevention services for Communities of High Need across the Commonwealth over the next five years.

APPROACH

The Executive Committee of the MA Interagency Council on Substance Abuse and Prevention (IAC), with members representing a wide range of government and non-government stakeholders, served as the "Policy Consortium" to oversee, participate in, and provide feedback to inform this SPE process. A "Working Group" - comprised of senior prevention staff from BSAS, the Executive Director of the IAC, representatives from the state's training and technical assistance provider, the SPE strategic consultants at Health Resources in Action (HRiA), a representative from the MA Department of Public Health's Data and Statistics Unit, and a representative from the BSAS evaluation team - was convened to carry out the SPE process in consultation with the Policy Consortium.

In conducting the SPE process and developing the deliverables, the Working Group followed the steps of SAMHSA's **Strategic Prevention Framework (SPF)**:[2]

- ***Step 1.*** *We **assessed** population needs (nature of the substance abuse problem, where it occurs, whom it affects, how it is manifested), the resources required to address the problems, and the readiness to act;*
- ***Step 2.*** *We created a **plan to build capacity** at State and community levels to address needs and problems identified in Step 1;*
- ***Step 3.*** *We developed a **comprehensive strategic plan**;*

Step 4. *We developed a* ***plan to implement*** *the evidence-based programs, practices, and policies identified in Step 3; and*

Step 5. *We developed a plan to monitor implementation,* ***evaluate*** *effectiveness,* ***sustain*** *effective activities, and improve or replace those that fail.*

As per the SPF, issues of **cultural competence and sustainability** were integrated throughout the SPE process.

To inform the assessment phase, BSAS commissioned an update of the MA Epidemiologic Profile (Epi Profile, updated by HRiA, attached). BSAS also commissioned HRiA to oversee an assessment of the substance abuse prevention-related needs of non-geographic populations within MA, specifically Native Americans (NA) and Military Families/Veterans (MFV), conducted by BSAS' regional centers for healthy communities. Evaluation of the needs of these special populations required sensitivity to each group's unique cultural aspects. Concurrently, the state's capacity was appraised to identify resources and gaps in each of four areas - Data Collection, Analysis, and Reporting; Coordination of Service; Performance Evaluation; and Technical Assistance/Training - forming the basis for four corresponding mini-plans. Cumulatively, these four mini-plans comprised our "Capacity Building/Infrastructure Enhancement Plan" – a comprehensive guiding document informed by and structured to mirror the SPF (see attached). The planning process commenced with prioritization of identified issues based on the updated Epi Profile, NA/MFV needs assessment, and the Capacity Building Plan. Once priority areas were selected, the Working Group continued to apply the SPF to develop: sustainable goals, objectives and strategies; logic models; an implementation/action plan; an evaluation plan; and a sustainability plan. Notably, the "**Next Steps" identified in the "Capacity Building/Infrastructure Enhancement Plan" were incorporated into the final strategic plan**. Comparable to our implementation of the SPE process, each element of this report aligns with the key components of the SPF.

In developing the plan, we conducted the following <u>specific activities</u>:

- Updated the state epidemiologic profile
- Examined current data related to the plan's nine elements
- Benchmarked epidemiological profiles of other states
- Assessed current prevention activities
- Assessed the needs and gaps related to extending prevention services to underserved populations, e.g., American Indian/Native Americans and military families
- Identified capacity building needs and issues through the development of four mini-plans (focused on: performance enhancement, data collection and monitoring, coordination of services, and technical assistance and training)
- Analyzed potential frameworks and strategies
- Decided on goals, objectives, strategies and activities
- Developed them into an integrated strategic plan that can be implemented over five years and sustained
- Incorporated potential cost savings strategies to align substance abuse prevention infrastructures across state agencies into the strategic plan.

MISSION/VISION

BSAS' existing mission and vision statements were reviewed. The Policy Consortium and Working Group agreed to uphold the existing language (below) as it is current, relevant and will guide the agency's work for the next five years.

Mission

"We foster healthy life choices through culturally responsive services that prevent, treat and promote recovery from substance related disorders."

Vision

We Believe:

- Substance related disorders can be prevented and must be treated as a chronic disease.
- In strengthening people through preventing treatment and recovery.
- Substance related disorders affect individuals, families and communities.
- Everyone in the Commonwealth must be treated with dignity and respect and must have access to quality ongoing care.
- Our services must be diverse and responsive to all cultures.
- Eliminating the stigmas associated with substance related disorders is integral to our prevention and treatment efforts.
- Recovery Works!

The ***components of the 5-Year,*** data-driven, outcomes-based ***Comprehensive Strategic Prevention Plan*** are detailed below, organized by SPF step, as well as per CSAP's outline provided in the RFP.

(A) PRIORITIZATION PROCESS FOR SELECTING STRATEGIC PLAN PRIORITIES

SPF STEP 1: ASSESSMENT

Step one of the SPF requires a careful analysis of trends in substance consumption and consequences (both long- and short-term), and review of existing resources, enabling identification and prioritization of current and emerging population needs and gaps in services. The following section details the assessment and prioritization processes completed by the Working Group, culminating in the identification of substance abuse prevention needs at the state and community-levels and selection of priority issues to address over the next five years.

BACKGROUND

In October 2006, the Governor of Massachusetts brought together statewide leaders in substance abuse prevention to form MassCALL2, the *Massachusetts Collaborative for Action, Leadership, and Learning,* to implement the Strategic Prevention Framework State Incentive Grant (SPF-SIG) to reduce substance abuse-related problems in communities, and build

prevention capacity and infrastructure at the state and community levels. As a first step in the SPF process, the Governor formed the Massachusetts Epidemiological Workgroup (MEW) to identify, gather, and analyze state and local data regarding substance abuse consequences and consumption patterns; associated causal factors, including risk and protective factors; existing resources and capacity; and current and planned prevention, intervention, treatment, and recovery programs.

The initial task of the MEW, to identify existing substance abuse consumption patterns and related consequences at the State level, began with a review of CSAP's State Epidemiological Data System (SEDS), and was gradually broadened to include other national and state datasets. To expedite this process, the MEW created a Data Working Group (DWG), consisting of epidemiologists and data analysts from many of the agencies represented on the MEW who possessed specific knowledge of data sources in their respective areas of expertise. This work resulted in the creation of the first Massachusetts Epidemiological Profile (Epi Profile), and the development of a data prioritization process.

Upon completion of this task, the MEW recommended priority areas on which to focus prevention, intervention, treatment, and recovery efforts to the Governor's Interagency Council on Substance Abuse and Prevention (IAC). The IAC chose the reduction of unintentional fatal and non-fatal opioid overdoses as the priority focus for MassCALL2.

The SPE project provided Massachusetts with the opportunity to update, broaden, revise, and replicate this earlier process in support of the development of its Comprehensive Strategic Prevention Plan. This section outlines the steps that were taken and the process that was followed to identify the proposed priorities for the Commonwealth over the next five years.

GUIDING PRINCIPLES

In consultation with the Massachusetts Department of Public Health (MDPH)'s Bureau of Substance Abuse Services (BSAS) and a representative from the Executive Committee of the IAC, the SPE Working Group was charged with updating the MA Epi Profile, revising the prioritization process, and making recommendations to the Executive Committee of the IAC. The following set of guiding principles was adopted to guide and inform this process: (1) the updated Epi Profile should reflect lessons learned from the earlier prioritization process, the experience of other states, and SAMHSA/CSAP and its contractors; (2) the prioritization process should be expanded to include consumption patterns, in addition to consequences; (3) the prioritization process should take into account and maximize coordination with *existing* plans, efforts, and priorities in the Commonwealth; (4) the process should be data-informed; and (5) the process should consider new and emerging issues that may not be accurately represented, given existing data limitations and availability.

APPROACH TO PRIORITIZATION PROCESS

Updating the Epi Profile

In preparation for updating the Massachusetts Epi Profile, the SPE Working Group examined several resources that were not available when the first Epi Profile was created. The two

principal documents reviewed were: (1) Developing a State Epidemiological Profile for Substance Abuse Prevention: Guidance for State Epidemiological Outcome Workgroups (PIRE, 2008); and (2) A Conversation About Measuring Risk and Protective Factors – The Latest Thinking (Park, Ballenger, Male, Love, & Kasat, 2011). The team also reviewed updated epidemiologic profiles created by other states (e.g., Maine) and made extensive use of SAMHSA/CSAP's Behavioral Health Indicator System (BHIS). Data were extracted in raw tabular form to assist in the prioritization process and were summarized and graphed to facilitate presentation in the updated Epi Profile. (The updated Epi Profile is attached.)

Inclusion of Consumption Data

The data prioritization process completed as part of the earlier SPF-SIG project placed exclusive focus on substance abuse consequences. The updated process was broadened to include consumption data. Drawing from the PIRE guidance document, the team decided to first examine the consequence data and then weave in the consumption data.

There are several reasons for concentrating first on substance related consequences. First, starting with details about preventable consequences provides the most information possible to design effective prevention strategies. By focusing on consequences, the scope of prevention assessment and planning may be broadened beyond consumption to include a wider array of causal factors implicated in each problem. For example, efforts to address alcohol-related motor vehicle crashes or alcohol-related poisonings may share some causal/risk and protective factors and strategies, but also have some causal/risk and protective factors that are unique to the consequence and necessitate strategies specific to the particular consequence.

Second, because consumption data are often self-reported, they may not always reflect substance abuse problems as accurately as measures of consequences. Starting with an examination of consequences might help focus in on more specific issues for prevention that might not be indicated by looking at consumption data alone. Third, policy makers' attention is often focused on the consequences of substance abuse and its associated costs. Thus, it is important to begin the descriptive epidemiological assessment process by looking at these outcomes, and then examining related consumption behaviors to better understand the outcomes.

After developing a better understanding of substance-related consequences and their distribution in the State, the next step is to explore the consumption patterns that lead to these consequences.

Examining consumption data is important for a number of reasons. Perhaps most obviously, consumption is the risk behavior that prevention experts seek to change. But even a single consumption pattern (e.g., binge drinking) often results in multiple consequences. Prevention experts must also consider that not all substance use necessarily leads to negative consequences (e.g. a drink a day for low risk groups) and thus may not reflect outcomes on

which prevention efforts need to focus. Finally, reliable, valid data is not always available on all substance-related consequences.

The relationships between consequences and consumption patterns are often complex, and require expertise to understand them. This is particularly the case for many substance-related problems that are multi-causal in nature, with numerous other factors contributing to the problem in addition to substance use. For example, although alcohol consumption is associated with violent crime, many other factors are also implicated and the influence of alcohol is difficult to disentangle from the effects of other factors. Other complexities include time lags as some consumption patterns lead to consequences almost instantly (e.g., alcohol-related motor vehicle crash after drinking and driving), while others (e.g., cigarette smoking leading to lung cancer) take longer time to manifest.

Using a sequential approach to prevention planning and assessment—examining adverse consequences and subsequently their associated use patterns—keeps relationships in mind, and organizes descriptive inquiry for understanding these relationships. In addition, it helps ensure that the focus is on consumption patterns that cause negative consequences.

Coordination with Existing Plans, Efforts, and Priorities

The SPE Working Group was instructed to take into account and maximize coordination with existing plans, efforts, and priorities in the Commonwealth. BSAS prevention programs are currently focused on addressing two primary issues: (1) underage alcohol use and (2) unintentional fatal and non-fatal opioid overdoses. The team was instructed to review and update any new or relevant data that could help inform the work of these ongoing initiatives.

Underage Alcohol Use: A priority issue at both the federal level and in Massachusetts is underage drinking. This issue has been identified by numerous federal agencies and has been the focus of the Massachusetts SAPT block grant prevention set aside. An examination of currently available data reveals that while progress is being made, this is still a substantial issue in the Commonwealth. Alcohol remains the substance of choice among underage youth in Massachusetts:

- 71% of high school students and 28% of middle school students report lifetime use of alcohol (MA YRBS & YHS, 2009).
- 17% of high school students report having their first drink of alcohol before the age of 13 years (MA YRBS & YHS, 2009).
- 44% of high school students and 11% of middle school students reported having an alcoholic beverage in the previous 30 days (MA YRBS & YHS, 2009).
- 25% of high school students and 4% of middle school students report binge drinking (having five or more drinks of alcohol in a row within a couple of hours) in the previous 30 days (MA YRBS & YHS, 2009).

Unintentional Fatal and Non-Fatal Opioid Overdoses: Another priority issue in Massachusetts, and increasingly across the nation, is unintentional fatal and non-fatal opioid overdoses. This

was the focus of the Massachusetts SPF-SIG. An examination of currently available data from "Opioids: Trends and Current Status in Massachusetts" MDPH (2009) reveals the following:

- The number of opioid-related poisoning deaths in Massachusetts is greater than the number of deaths from motor vehicle accidents.
- In 2007, deaths due to opioid-related overdoses (n=637) were over 6 times the number in 1990 (n=94).
- The crude rate for opioid-related poisoning deaths increased 156% between 1990 and 1998 (from 1.6 to 4.1 per 100,000), and 90.4% between 1999 and 2007 (from 5.2 to 9.9 per 100,000).
- For every one opioid-related fatal overdose in 2007, there were 47 nonfatal incidents treated at Massachusetts acute care hospitals.
- Rates of opioid-related inpatient hospital discharges have risen substantially since FY1997, increasing 84.6% from FY1997 to FY2007 (from 151.3 to 279.3 per 100,000)
- In FY2007, there were 18,015 nonfatal opioid-related hospital discharges among Massachusetts residents (279.3 per 100,000).
- Rates of opioid-related ED discharges increased 18.6% from FY2002 to FY2007.

DATA INFORMED PRIORITIZATION PROCESS

The prioritization process had two goals. First, to identify and incorporate any new or updated data on underage drinking and opioid use – based on indicators of consequences and, secondarily, consumption data - to quantify the scope of the problems and to identify high risk sub-groups. Second, to examine a wider range of substance abuse consequence data to identify any new or emerging issues and to then trace these back to consumption patterns as recommended in the PIRE guidance document.

The process for narrowing down the list of indicators and identifying the priority areas involved three phases.

- *Phase 1: Assessment of Magnitude, Trends, and Comparisons* focused documenting and then scoring four epidemiological criteria: 1) size/magnitude of substance abuse consequences; 2) trends over time; 3) consumption patterns; and 4) relative comparisons.
- *Phase 2: Assessment of Impact* included three additional criteria: 1) changeability; 2) directionality; and 3) preventability.
- *Phase 3: Final Decision Making* considered: 1) magnitude; 2) capacity; 3) perceived gap between resources and need; and 4) political will.

A parallel process was undertaken to assess substance abuse issues of Native Americans and military families across the Commonwealth. Each of the six Regional Centers for Healthy Communities searched for relevant data sources and interviewed key stakeholders to explore these issues. (Summary Report attached.)

LIMITATIONS OF THIS PRIORITIZATION PROCESS APPROACH

There were a number of limitations in this process that should be acknowledged and corrected in the future, to the extent possible. These limitations included:

- The accelerated SPE planning process necessarily truncated the amount of time the state was able to devote to the prioritization process. The original prioritization process spanned close to one and a half years. This work was done in little over three months.
- Given the truncated timeline, the SPE Working Group was not able to examine as many consequence indicators as it had in the past.
- Structurally, there continues to be a marked dearth of data available at the state-level and county or community levels for related data.
- There is a reporting lag at both the national and state-level of up to 2-4 years for some indicators (e.g., overdose data).
- Due to lack of specificity regarding causality of some consequence indicators (e.g. for overdose, suicide, lung disease and heart disease), it is not possible to measure the proportion attributable to use of specific substances.
- Reporting of arrest data (UCR) is not mandatory and therefore does not include all cities/towns in MA. Most notably, it excludes the city of Boston, an urban area with some of the highest consumption and consequence rates in the state.
- Not all consumption patterns of potential interest (e.g., marijuana use) have easily identified short-term consequences. The selection of consequence data is driven more by availability than by comprehensiveness. This makes it unlikely that certain areas will ever rise to the top – which necessitates the inclusion of softer (e.g., anecdotal, small study) data to complement state and national datasets.

FINDINGS OF THE ASSESSMENT AND PRIORITIZATION PROCESS

State-level data from the following datasets were retrieved from SAMHSA's Behavioral Health Indicator System and included in the prioritization process:

- Behavioral Risk Factor Surveillance System (BRFSS)
- Fatality Analysis Reporting System (FARS)
- National Vital Statistics System Mortality (NVSS-M)
- National Survey on Drug Use and Health (NSDUH)
- Pregnancy Risk Assessment Monitoring System (PRAMS and NVSS-B)
- Sales data from the Alcohol Epidemiologic Data System (AEDS)
- Sales data for tobacco products
- Treatment Episode Data Set (TEDS)
- Uniform Crime Reporting (UCR)
- Youth Risk Behavior Survey (YRBS)

The consequences examined were:

- Drinking and Driving
    - Alcohol-related fatal crashes
    - Alcohol-involved crash death rate
- Mortality
    - Drug overdose deaths

    - Homicide deaths
    - Lung cancer deaths
    - Lung disease deaths
    - Suicide deaths
    - Heart/Stroke deaths
- Teen Pregnancy
    - Teen pregnancy rate
- Treatment
    - Substance abuse treatment admissions
- Arrests
    - Drug-related arrests
    - Arrests for DUI
    - Arrests for drunkenness
    - Arrests for liquor law violations
- Overdose
    - Emergency Department discharges for non-fatal overdose
    - Inpatient discharges for non-fatal overdose

Phase 1: Assessment of Magnitude, Trends, and Comparisons

Step 1: Size/ Magnitude of Consequences

Direction and magnitude of change were calculated for each consequence. This epidemiological dimension explored the basic question of "how big" each consequence of substance use/abuse was in terms of its occurrence. Given that most of the consequence indicators available in the BHIS and those retrieved specifically for the updated Massachusetts Epidemiological Profile were expressed as either incident or prevalence rates, the SPE used the *crude rate per 100,000 population* as its standard measure of size/magnitude. The crude rate conversions facilitated relative comparisons across different geographic units and populations or sub-populations by identifying areas or groups where levels of problems or behaviors were atypically high in ways that cannot be explained simply by differences in population size alone.

Table 1 presents the crude ranking per 100,000, trends over time and comparison to national benchmarks for each of the substance abuse-related consequences that were considered in Phase 1. The MA Trend Direction column indicates whether or not the rate has increased, decreased, or remained the same over the most recent three years of data. The US Comparison Trend Direction column presents this same information for the three most recent years using national data (i.e., did the 3-year rate increase, decrease, or remain the same. The last column, MA to US Trend Direction, indicates whether or not the MA 3-year rate is higher, lower, or the same as the US 3-year rate.

Table 1: Substance Abuse Consequence Indicators (by Crude Rate)

Note: ↓ indicates decreasing rates, or lower than; ↑indicates increasing rates, or higher than

Indicator	MA Crude Rate per 100k Most Recent Year	MA Count Most Recent Year	MA Trend Direction	US Comparison Trend Direction	MA to US Trend Direction
Teen Pregnancy (age 15-19)	4,951.92	10,290	↓	↓	↓
Substance Abuse Treatment Admissions	1,300.99	85,782	↓	=	↑
Heart/Stroke Deaths	240.97	15,542	↓	↓	=
Arrests/Drug - All Ages	184.59	12,086	↓	↓	↓
All Arrests - DUI	177.68	11,634	↓	↓	↓
All Arrests - Drunkenness	113.67	7,443	↑	↓	↓
All Arrests - Liquor Laws	70.27	4,601	↑	↓	↓
Juv. Arrests - Liquor Laws	68.71	975.00	↑	↓	↓
Death from Lung Cancer	55.96	3,609	↓	=	↑
Arrests/Drug - Under 18	46.73	663	↓	↓	↓
Death from Lung Disease	35.43	2,285	↓	=	↓
Death from OD - Age 35 to 54	30.31	595	↑	↑	↑
ED Discharge for non-fatal OD	29.34	1,921	↓	NA	NA
Death from OD - Age 30 to 34	22.09	91	↑	↑	↑
Death from OD - Age 21 to 29	19.20	148	↑	↑	↑
Death from OD - Male	18.77	587	↑	↑	↑
Juv. Arrests - Drunkenness	16.28	231	↑	↓	↑
Inpatient Discharge non-fatal OD	15.46	1,012	↓	NA	NA
Death from OD	14.30	922	↑	↑	↑
Death from OD - Age 55 to 64	13.11	92	↑	↑	↑
Death from OD - Female	10.08	335	↑	↑	↑
Death from Suicide	8.00	516	↑	=	↓
MVCA/Alc/Death Rate-21 to 29	7.70	NA	↑	=	↓
Death from OD - Age 18	6.84	19	↑	↑	↓

Indicator	MA Crude Rate per 100k Most Recent Year	MA Count Most Recent Year	MA Trend Direction	US Comparison Trend Direction	MA to US Trend Direction
to 20					
Death from OD - Age 0-29	6.69	167	↑	NA	NA
MVCA/Alc/Death Rate-18 to 20	6.40	NA	↓	=	↓
Juv. Arrests – DUI	5.50	78	↓	↓	↓
MVCA/Alc/Death Rate-35 to 54	3.30	NA	↑	↓	↓
MVCA/Alc/Death Rate-30 to 34	3.10	NA	↑	↓	↓
Death from OD - Age 65 +	2.92	25	↑	↑	↓
Death from Homicide	2.88	186	=	↓	↓
MVCA/Alc/Death Rate	2.29	149	↓	↓	↓
MVCA/Alc/Death Rate-65 +	1.90	NA	↑	↓	↓
MVCA/Alc/Death Rate-12 to 17	1.80	NA	↓	↓	↓
MVCA/Alc/Death Rate-55 to 64	1.60	NA	↓	↓	↓
Death from OD - Age 0 to 11	0.00	0	=	↑	↓
Teen Pregnancy (age <=14)	NA	200	NA	↓	↓

Step 2: Trends over Time

This dimension focused on the extent to which each consequence indicator has changed in Massachusetts. This assessment was grounded in the most recent data available for each indicator. Time periods between initial and follow-up points vary due to lack of standardized data collection schedules. However, for each indicator a spread of at least two years was examined.

Step 3: Relative Comparisons

This dimension involved comparing individual Massachusetts consequence indicators, trends and consumption rates to a standard reference. The SPE chose "Comparison to National Rates" as the standard reference for comparing indicator values. Indicator values that were

substantially higher or increasing more rapidly than the national rates were considered problems that warranted priority attention.

Step 4: Consumption Patterns

Consumption data delineated in the updated Epi Profile, as related to the consequences, was examined to identify directionality and magnitude of change, trends of time and compared to national benchmarks.

Step 5: Scoring Rubric

A scoring rubric was created to rank MA trends over time and comparisons to national data trends, as follows.

- Indicators for which the most recent data point showed at least a 2.5% increase compared with the previous data point were awarded three priority points.
- Current indicators within the same range (i.e., plus or minus 2.5%) as the earlier values received two points.
- Indicators that showed at least a 2.5% decrease between the two time points received one priority point.
- MA indicators that were at least 5% higher than the national average (for the most recent year available) received three priority points.
- Indicators within the same range as national benchmarks (plus or minus 5%) received two priority points.
- Indicators that showed at least a 5% decrease compared to the national average received one priority point.
- The total for each indicator was calculated by adding the MA trend and U.S. comparison points together, for a maximum of 6 points per indicator.

Phase 1 Results:

Table 2 presents the results of the scoring process for Massachusetts, the U.S., Massachusetts versus the U.S., and the total number of points awarded for each consequence indicator.

Table 2: Substance Abuse Consequence Indicators (by Points)

Indicator	MA Crude Rate per 100k Most Recent Year	MA Trend Points	US Trend Points	MA/US Trend Points	Total Points* [MA trend + US trend]
Death from OD	14.30	3	3	3	6
Death from OD - Age 21 to 29	19.20	3	3	3	6
Death from OD - Age 30 to 34	22.09	3	3	3	6
Death from OD - Age 35 to 54	30.31	3	3	3	6
Death from OD - Age 55 to	13.11	3	3	3	6

Indicator	MA Crude Rate per 100k Most Recent Year	MA Trend Points	US Trend Points	MA/US Trend Points	Total Points* [MA trend + US trend]
64					
Death from OD - Male	18.77	3	3	3	6
Death from OD - Female	10.08	3	3	3	6
Juv. Arrests - Drunkenness	16.28	3	1	3	6
Substance Abuse TX Admissions	1,300.99	1	2	3	4
All Arrests - Drunkenness	113.67	3	1	1	4
All Arrests - Liquor Laws	70.27	3	1	1	4
Juv. Arrests - Liquor Laws	68.71	3	1	1	4
Death from Lung Cancer	55.96	1	2	3	4
Death from Suicide	8.00	3	2	1	4
Death from OD - Age 18 to 20	6.84	3	3	1	4
Death from OD - Age 65 +	2.92	3	3	1	4
MVCA/Alc/Death Rate- 21 to 29	7.70	3	2	1	4
MVCA/Alc/Death Rate- 35 to 54	3.30	3	1	1	4
MVCA/Alc/Death Rate- 30 to 34	3.10	3	1	1	4
MVCA/Alc/Death Rate- 65 +	1.90	3	1	1	4
Heart/Stroke Deaths	240.97	1	1	2	3
Death from OD - Age 0 to 11	0.00	2	3	1	3
Death from OD - Age 0-29	6.69	3	NA	NA	3
Death from Homicide	2.88	2	1	1	3
Teen Pregnancy (age 15-19)	4,951.92	1	1	1	2
All Arrests - DUI	177.68	1	1	1	2
Arrests/Drug - All Ages	184.59	1	1	1	2
Arrests/Drug - Under 18	46.73	1	1	1	2
Juv. Arrests – DUI	5.50	1	1	1	2
Death from Lung Disease	35.43	1	2	1	2
MVCA/Alc/Death Rate	2.29	1	1	1	2
MVCA/Alc/Death Rate- 12 to 17	1.80	1	1	1	2
MVCA/Alc/Death Rate- 18 to 20	6.40	1	2	1	2
MVCA/Alc/Death Rate- 55	1.60	1	1	1	2

Indicator	MA Crude Rate per 100k Most Recent Year	MA Trend Points	US Trend Points	MA/US Trend Points	Total Points* [MA trend + US trend]
to 64					
ED Discharge for non-fatal OD	29.34	1	NA	NA	1
Inpatient Discharge non-fatal OD	15.46	1	NA	NA	1
Teen Pregnancy (age <=14)	NA	NA	1	1	1

Eight consequences earned the maximum of six points. These were collapsed into two categories:

- Death from overdose (OD): both genders, age groups 21-29, 30-34, 35-54, 55-64 (total of 7 individual indicators)
- Juvenile arrests for drunkenness

Eleven consequences earned the next highest score of four points.

- Death from OD, age groups 18-20, 65+
- Juvenile arrests – liquor laws
- All arrests - liquor laws
- All arrests – drunkenness
- Alcohol related motor vehicle deaths (ages 21-29, 30-34, 35-54, 65+)
- Death from lung cancer
- Death from suicide

Teen pregnancy, substance abuse treatment admissions and heart disease/stroke deaths were the three consequences with the highest crude rates in MA. However, these indicators were eliminated for the following reasons: teen pregnancy is addressed by other state agencies; an increase in substance abuse treatment admissions can be a positive indicator; and heart disease/stroke deaths are multi-factorial, not likely to be changed significantly by a substance abuse prevention strategy alone, and also addressed by multiple state agencies.

Phase 2: Assessment of Impact

In the second phase of prioritization, the SPE included three additional criteria: 1) changeability; 2) directionality; and 3) preventability.

Step 1: Changeability

Some consequences may be re-mediated or cured in a relatively short time; others may take years and, therefore, may be less compelling as a focus of intervention. For example, it may take years to reduce rates of alcohol-related cirrhosis or tobacco-related lung cancer. Given the five year time frame covered by the Comprehensive Strategic Prevention Plan, the SPE Working

Group decided to eliminate all consequence indicators that would be unlikely to demonstrate change within the next 5 years.

Step 2: Directionality
It may be difficult to determine the direction of an intended outcome for some consequences (e.g. drug abuse violations may go up rather than down as a result of increased enforcement activities).

Phase 3 Results:
As a result of the steps above, several consequences were eliminated from consideration as priorities based on inability to make a significant impact within a five year time period via substance abuse prevention strategies and/or lack of compelling data regarding trend directionality. These are listed in Table 3 below.

Table 3: Consequences Eliminated from Prioritization Process

Consequence	Failed Criteria
Heart/Stroke deaths	Changeability
Deaths from lung cancer	Changeability
Arrest/Drug –all ages	Directionality
All arrests-DUI	Directionality
All arrests-Drunkenness	Directionality
All arrests liquor laws	Directionality
Juvenile arrests – liquor laws	Directionality
Arrests/drugs- under 18	Directionality
Juvenile arrests-drunkenness	Directionality
Suicides	Directionality

Phase 3: Final Consequence Decision Making Criteria
The SPE Working Group determined which indicators to recommend to BSAS, and in turn to the IAC, for consideration as a result of the criteria below, considered during Phase 3 of this prioritization process.

Step 1: Preventability
This refers to the extent to which proven (evidence-based) methods for preventing the problem exist. While there are some areas in which substantial progress has been made in developing evidence-based interventions (e.g., substance abuse, depression), there are others where this information is new and emerging (e.g., overdose prevention, opioid specific practices).

Step 2: Capacity
This refers the ability of the Commonwealth to address the problem in relation to available resources, the state prevention infrastructure, and the magnitude of the problem.

Step 3: Perceived Gap between Resources and Need

A consequence may impose a large burden in magnitude and social costs, but if it is one to which the Commonwealth is already devoting considerable resources, it may be worth focusing on less burdensome problems to which fewer resources have been devoted. Trend data can be important to consider in this situation. For example, if the more serious problem has trended downward in magnitude, this may indicate that the resources devoted to it are sufficient to continue this positive movement.

Step 4: Political Will

Although difficult to quantify, the desire of political leaders and/or public will to address a need, are important factors to consider. The guidance of the IAC as the oversight body gives the SPE insight into the political will at the legislative and agency head level.

Phase 3: Final Prioritization Results

Examination of the available data identified death from overdose (both genders, age groups 21-64) and juvenile arrests for drunkenness as the two substance abuse-related consequences that should be prioritized as part of the Massachusetts Comprehensive Strategic Prevention Plan. While the juvenile arrest data are problematic due to issues of directionality and interpretation, the consequence hints at the underlying consumption pattern as being an area of concern. Based on these findings and the Commonwealth's interest in maximizing coordination with *existing* plans, efforts, and priorities, the SPE Working Group recommends that the 5-year Comprehensive Strategic Prevention Plan place primary focus on:

1) **Prevention/Reduction of Underage Drinking**

2) **Prevention/Reduction of Unintentional Fatal and Nonfatal Opioid Overdoses**

New and Emerging Issues

In addition to the two priorities identified above, the SPE Working Group also recommends that the Comprehensive Strategic Prevention Plan consider ways to enhance the state's ability to track, monitor and report on prevention activities, substance abuse patterns, and emerging issues using existing and new data sources. Four initial priority populations and areas include: (1) Native Americans, (2) Military Families, (3) youth marijuana use, and (4) prescription drug abuse.

Native Americans & Military Families

The Massachusetts Department of Public Health (DPH) Bureau of Substance Abuse Services (BSAS) conducted an assessment to further explore the needs of Native American Indian (NAI) as well as Military Family and Veteran (MFV) populations with respect to substance abuse, mental health, and co-occurrence.[3] The assessment consisted of an analysis of existing secondary data (Phase 1) supplemented with key informant interviews (Phase 2). The following **research questions** guided this assessment process:

- Who comprises the NAI population in MA? Where do they access services for mental health and substance abuse?
- Who comprises the MFV population in MA? Where do they access services for mental health and substance abuse?
- What are the mental health and substance abuse issues and needs (prevention, intervention and treatment) of NAI and MFV in MA?
- How do these compare to those of the general population of MA?
- What unique challenges do NAI and MFV face in trying to access MH and SA services and resources?

*The **goals** of the NAI/MFV assessment were to:*

- Gain an understanding of NAI population in MA in terms of demographics and geography.
- Gain an understanding of MFV in MA in terms of demographics and geography.
- Identify and compile existing relevant data, while also identifying gaps in data (availability, quantity and quality).
- Identify key informants (among and working with) NAI and MFV populations.
- Gain an understanding of mental health and substance abuse resources available to NAI and MFV in MA, so as to identify gaps and leverage existing resources.
- Gain an understanding of approaches that are *culturally appropriate* for these populations.
- Enable BSAS to plan substance abuse prevention services with careful consideration of the specific needs and *unique cultural nuances* of NAI and MFV populations.

The full report is attached to this plan. Highlights of the findings are described below.

Overview of Populations

Both Native American Indians (NAI) and Military Families and Veterans (MFV) are federally recognized populations, with separate and parallel systems for health care, including behavioral health care. Although conceptualized as separate populations with distinct health issues, there is a great deal of overlap. NAI serve as active military personnel, and comprise military families and veterans. Moreover, substance abuse and mental health are not distinct issues; therefore, the assessment addresses co-occurrence.

There appears to be a good deal of protectiveness on the part of both NAI and MFV populations, in terms of controlling access to data, and in not revealing unflattering aspects of their community to outsiders. Despite outreach to more than 56 programs, organizations and individuals throughout the Commonwealth, Phase I of this assessment did not yield any new data pertaining to either target population, with respect to substance abuse or mental health.

Health Services for NAI and MFV populations

Segmentation and lack of coordination of health services was also raised as an area of concern, particularly at the federal level. The Indian Health Service (IHS) situated in Nashville, Tennessee, is responsible for serving all NAI living east of the Mississippi River. Service areas for Veterans

in MA are also fragmented, with some Veterans in the Southeast being referred to Rhode Island Veterans' offices. Such a situation leads to divided care across state lines. The lack of statewide and state-to-state coordination of services, makes tracking the need for health services and utilization of existing services difficult for both populations.

NAI-Specific Issues

According to the U.S. Bureau of Indian Affairs, there are two federally recognized tribes in MA: the Mashpee Wampanoag Tribe, and the Wampanoag Tribe of Gay Head (Aquinnah). Given the benefits conferred with this federal status, tribe recognition is a contentious issue as there are at least 40 other tribes in the Commonwealth.

Key informants described the following concerns regarding the magnitude of substance abuse (SA) and mental (MH) health issues among the NAI population in MA:

- The intergenerational and inter-related nature of SA and MH issues facing NAI
- Stigma around discussing these issues
- A scarcity of culturally sensitive programs for the NAI population
- Existing gaps in services for the NAI population as a whole, and specifically among members of tribes not recognized by state or federal government

Historical trauma, employment, age, and Veteran status were dominant themes when participants described the NAI population in MA. High rates of unemployment, poverty and disease contribute to the issue of addiction, in addition to culture-specific historical trauma. Given the cultural issues unique to NAI tribes, informants emphasized the **importance of including the MA's NAI population as an important resource for addressing substance abuse and mental health needs amongst themselves**.

The **majority of responses regarding substance abuse and mental health issues focused on *treatment***. Challenges described by participants included: stigma around acknowledging and seeking care for mental health or substance abuse issues; a need for more programs that were culturally sensitive, target the NAI population in MA, and were informed by a process of community engagement; and gaps in services for the NAI population as a whole, but particularly for members of tribes not recognized by the state or federal government.

Gaps in Services for NAI

While gaps in services were identified for the NAI population in MA in general, this issue was particularly acute for tribes not recognized by the state or federal government. Several participants noted that state and federal funding for substance abuse and mental health issues for the NAI population were contingent upon recognition of the tribe by the Commonwealth of Massachusetts or the federal government. Consequently, members of tribes that were not recognized by the state or federal government had more limited access to funded services. The majority of participants called for **efforts to address substance abuse and mental health concerns among the NAI population that truly engage the NAI community**.

MFV-Specific Issues

Participants described concerns regarding:

- The high prevalence and duration of substance abuse and mental health issues among MFV in MA
- The interconnected relationship between substance abuse and mental health
- A need to identify substance abuse and mental health issues earlier
- A need to raise awareness among MFV regarding available services
- Inadequate access to substance abuse and mental health services
- A need to enhance access to detoxification programs while ensuring that there is more continuity of care throughout the recovery process.
- Existing gaps in services

Employment, social isolation, family circumstances, number of deployments, and time since return from combat were dominant themes when participants described risk factors for substance abuse and mental health issues. Prescription drugs use among active military members and veterans was the most frequently mentioned issue, followed by alcohol abuse, and thirdly, opioid abuse. Among mental health issues, PTSD was the most common concern mentioned facing MFV in MA, followed by depression, anxiety, and traumatic brain injury as other important mental health issues. Further, informants explained that dual diagnoses were predominant among the MFV community in MA.

As with NAI informants, the **majority of MFV respondents focused on *treatment* of substance abuse and mental health issues**. While participants cited several challenges to accessing and utilizing services, they also valued several existing programs. Identified gaps included care for veterans with a dishonorable discharge, limited resources for female military members, as well as spouses and other family members of both active service members and veterans.

Conclusions of the NAI/MFV Assessment

Despite their relatively small numbers, Native American Indians and Military Families and Veterans are populations of great importance in Massachusetts. While the Commonwealth strongly recognizes the significance of these populations, there needs to be a coordinated effort to provide a network of service and support that leaves no one behind. The assessment process identified individuals and organizations who are willing to come together to create more cohesiveness in services for these populations. A coordinated, collaborative effort grounded in communication among service organizations and agencies could help address some of the barriers identified through this assessment process. **Gathering and sharing of data will be essential**, in addition to creating a foundation for terms, definitions and pertinent factors to be tracked over time. Consistent tracking of statistics and information will yield trend data that will pave the way to more efficient and effective services. This data is critical to the enhancement of existing SA and MH assets, and the expansion of services where need is evident will have a direct impact on the well-being of NAI and MFV populations in MA.

***Youth Marijuana Use*.** In January 2009, Massachusetts made changes to its marijuana possession laws for small amounts of marijuana. Possession of one ounce or less of marijuana for individuals over 18 is a civil offense, subject to a $100 fine. Offenders under 18 years of age

are required to attend a drug awareness program or pay a $1,000 fine. While the impact of this change is still unclear, anecdotal evidence suggests that marijuana use may be increasing. Available data from the MA YRBS indicate:

- In 2009, 43% of MA high school students and 37% of US high school students reported using marijuana over their lifetime.
- From 2003 to 2009 the prevalence of lifetime use of marijuana was 3-7% greater for MA high school students compared to US high school students.
- In 2009, a greater percentage of MA high school students (27%) reported current marijuana use compared to US high school students (21%).
- Over the period of 2003 to 2009, a greater proportion (5-6% greater) of MA high school students reported current use of marijuana (within the past 30 days) compared to US high school students.

More work is needed in this area to effectively monitor use in this population and to identify potential consequences of use.

Prescription Drug Abuse: The state's current focus on unintentional fatal and non-fatal opioid overdoses places primary emphasis on addressing the intervening variables that are proximal to the overdose event (e.g., concomitant use of substances, fear of calling 911, lack of knowledge of the risk factors for overdose). Based on guidance from the data available, most of this work focuses on the older group of career opioid abusers – those at highest risk for overdose. Comparatively less attention has been paid to primary prevention efforts targeting this issue (i.e., demand-reduction strategies). National and regional data increasingly suggest that a growing proportion of the population are misusing and abusing prescription drugs. Among some individuals, the misuse or abuse of prescription drugs can lead to a cross-over into other opioids, such as heroin. More work is needed to understand the etiology of prescription drug misuse and abuse in the Commonwealth.

(B) DATA-DRIVEN GOALS AND OBJECTIVES

SPF Step 3: PLANNING (See Goals 3 & 4 below)

The planning phase of the SPF calls for the development of a comprehensive strategic plan. Once priority issues were identified and selected via the prioritization process, based on the updated MA Epidemiology Profile, the Working Group developed Goals, Objectives and actionable Strategies that can be quantified, monitored and evaluated for change over time. These prevention planning areas are reflected in Goal 3 and Goal 4, delineated below. For these substance-specific goals, the SPF was particularly useful in guiding development of objectives. Performance evaluation and technical assistance domains identified in the Capacity Building/Infrastructure Enhancement Plan have been incorporated into Goals 3 and 4.

(C) GOALS, OBJECTIVES, AND STRATEGIES FOR COORDINATING SERVICES

SPF Step 2: CAPACITY BUILDING (See Goals 1 & 2 below)

As a result of the Capacity Building/Infrastructure Enhancement Plan, the Policy Consortium and Working Group identified several areas in which capacity needs to be expanded at state and community levels to address the needs and problems identified by the updated MA Epi Profile. "Next Steps" outlined in the Capacity Building/Infrastructure Enhancement Plan were examined and incorporated into the relevant areas of the strategic plan. One area in which BSAS intends to build capacity is in the state's system for collecting, storing and analyzing data related to substance abuse prevention - within MDPH, as well as in a coordinated fashion across state agencies. Another area in which capacity will be enhanced focuses on coordination of substance abuse prevention resources and programming across public and private service delivery systems, including primary and mental health care. These areas are detailed below in Goal 1 and Goal 2.

APPROACH TO DEVELOPMENT OF GOALS, OBJECTIVES AND STRATEGIES

The Working Group was guided through a rapid strategic planning process by an external facilitation team during three half-day retreats. Draft goals, objectives and strategies were developed during these planning retreats and further reviewed, refined and vetted by BSAS senior prevention staff and the Policy Consortium following each planning session. Cultural competency and sustainability strongly influenced the strategic planning process. Four final goals were agreed upon, each with measurable objectives and actionable strategies (below).

GOALS, OBJECTIVES AND STRATEGIES

GOAL 1: Enhance the state's ability to track, monitor and report on prevention activities, substance abuse patterns, and emerging issues using all available data sources.

Objective 1.1: Finalize BSAS' web-based reporting system within six months.

Strategies:

- 1.1.1 Review structure of data system and provide feedback to database development team.
- 1.1.2 Design and implement a strategy to communicate certification requirement to funded and non-funded communities.
- 1.1.3 Begin process of certifying all prevention programs (municipalities and agencies) across the Commonwealth.
- 1.1.4 Develop training manual for the reporting system and provide to all funded programs.
- 1.1.5 Finalize format of automated reports.
- 1.1.6 Review and finalize process for NOMS reporting.

Objective 1.2: Promote and increase data sharing among agencies within two years.

Strategies:

- 1.2.1 Reinstitute Massachusetts Epidemiological Workgroup (MEW) and expand membership.
- 1.2.2 Activate Memorandum of Understanding (MOU) for each member of the MEW related to sharing data.

1.2.3 Identify point of contact for data in each state agency.
1.2.4 Obtain clarification of data expectations from each statewide partner, involving the MEW as appropriate.
1.2.5 Collaborate with the Governor's Interagency Council (IAC) to gain access to the most current data available from each member.
1.2.6 Work within MPDH to obtain all current substance use and abuse related data available from each Office and Bureau.

Objective 1.3: Expand means to store, organize, and analyze inter-agency and inter-departmental substance use and abuse-related data within five years.
Strategies:

1.3.1 Build infrastructure to house collected data.
1.3.2 Determine how the data collected fits within the system.
1.3.3 Determine how to organize and report data.
1.3.4 Build internal capacity to analyze collected data.
1.3.5 Explore progress to make data more accessible to communities and stakeholders.
1.3.6 Update MA Epidemiologic Profile annually.

Objective 1.4: Develop new mechanisms to collect data to help identify Communities of High Need and emerging substance use and abuse issues, periodically.
Strategies:

1.4.1 Use work groups to review current surveillance systems.
1.4.2 Explore new opportunities to collect and analyze data.
1.4.3 Identify gaps in resources and/or health disparities for subpopulations (based on identity: Native Americans, LGBTQ, etc., and based on setting: military families, college students, etc.)
1.4.4 Develop new surveillance models.

GOAL 2: Enhance collaboration, coordination, and alignment within and among state agencies and other stakeholders, including primary health care and mental/behavioral health care, to prevent/reduce substance abuse.

Objective 2.1: Leverage and align state-wide funding streams and resources for prevention by identifying state agencies and other stakeholders, including primary health care and mental/behavioral health care, working to prevent/reduce substance abuse.
Strategies:

2.1.1 Survey state agencies to identify resources (financial, programmatic, community) invested in substance abuse prevention services within 9 months of plan approval.
2.1.2 Survey non-state stakeholders, including primary health care and mental/behavioral health care, to determine investment of governmental and nongovernmental resources in substance abuse prevention services within one and a half years of plan approval.

2.1.3 Develop an inventory of programs and funding for substance abuse prevention services among state agencies and other stakeholders, including primary health care and mental/behavioral health care, within one year.

2.1.4 Highlight existing collaborations among state agencies and other stakeholders, including primary health care and mental/behavioral health care.

Objective 2.2: Develop strategies to enhance, coordinate, redirect and align prevention efforts among state agencies and other stakeholders, working with the MA Department of Mental Health (DMH) where the priorities and populations overlap.

2.2.1 Share inventory of programs and funding for substance abuse prevention services among state agencies and other stakeholders with IAC.

2.2.2 Identify opportunities for increased coordination of substance abuse prevention efforts and resources.

2.2.3 Identify common/shared guidelines for funding allocation among state agencies and other stakeholders.

2.2.4 Design a collaborative process for identifying and obtaining new funding resources.

2.2.5 Explore potential sources for reimbursement that may become available through health care reform.

Objective 2.3: Develop a process to ensure that prevention funding and resources include Communities of High Need (including subpopulations based on identity: Native Americans, LGBTQ, etc., and based on setting: military families, college students, etc.), based on prevalence rates and data analysis over five years.

Strategies:

2.3.1 Review all available data within a five-year period to identify Communities of High Need.

2.3.2 Design a funding formula, based on available state and other stakeholder resources, that prioritizes Communities of High Need.

Objective 2.4: Evaluate changes in collaboration and coordination within and among state agencies and other stakeholders, including primary health care and mental/behavioral health care, to prevent/reduce substance abuse.

Strategies:

2.4.1 Design and implement an evaluation tool to capture changes in collaboration and coordination.

GOAL 3: Prevent/Reduce substance abuse, with a continued focus on underage drinking.

Objective 3.1: Identify communities of greatest need based on most current statewide data, every three years.

Strategies:

3.1.1 Obtain all current available substance abuse-related consumption and consequence data on with a focus on underage drinking.

3.1.2 Define criteria to determine Communities of Greatest Need.

3.1.3 Generate updated statewide MA Epi Profile.

3.1.4 Identify Communities of Greatest Need and prioritize based on prevalence rates, capacity, and readiness.

Objective 3.2: Allocate resources to Communities of Greatest Need across the state to support the prevention/reduction of substance abuse and/or underage drinking over the next five years.

Strategies:

3.2.1 Apply for relevant grants.

3.2.2 Identify, coordinate, and align resources for substance abuse prevention with other state prevention providers (or agencies).

3.2.3 Continue to identify and engage key community stakeholders and local champions to prevent/reduce underage drinking.

3.2.4 Increase the number of community sectors engaged in policy/practice change to prevent/reduce underage drinking.

3.2.5 Continue to identify and engage legislators to champion policy changes to prevent/reduce underage drinking.

Objective 3.3: Increase capacity statewide to prevent/reduce substance abuse and/or underage drinking by increasing the number of communities engaged in/implementing this work over five years.

Strategies:

3.3.1 Implement prevention certification process with interested communities.

3.3.2 Integrate the Strategic Prevention Framework as a planning model in all funded programs and communities, and offer training/technical assistance on the SPF process.

3.3.3 Reassess funding based on performance and/or reach/impact annually.

3.3.4 Explore mentoring relationships within and among community clusters.

Objective 3.4: Increase statewide capacity to prevent/reduce substance abuse with a focus on underage drinking by increasing the number of communities that implement and sustain a SPF-based, comprehensive prevention approach that includes evidence-based policies, programs and strategies and/or environmental strategies, within one year.

Strategies:

3.4.1 Use the BSAS certification process to increase the number of communities using a SPF-based, comprehensive prevention approach that includes evidence-based policies, programs and strategies and/or environmental strategies.

3.4.2 Provide training/technical assistance to communities and non-geographic communities to build capacity to acquire prevention funding.

3.4.3 Provide training/technical assistance to build capacity to implement and evaluate evidence-based policies, programs and strategies and/or environmental strategies based on the SPF process.

3.4.4 Continue to increase public awareness about underage drinking through public information initiatives/media campaign.

Objective 3.5: Evaluate the impact of statewide efforts on substance abuse and underage drinking within one year.

Strategies:

- 3.5.1 Ensure all BSAS prevention efforts are evaluated.
- 3.5.2 Perform YRBS data analysis in-house for trends and for comparison with other communities.
- 3.5.3 Look at archival data for trends.
- 3.5.4 Require funded communities to submit evaluation data (with core measures).

GOAL 4: Prevent/Reduce fatal and non-fatal opioid overdoses.

Objective 4.1: Identify Communities of Greatest Need based on all current statewide opioid overdose data, every three years.

Strategies:

- 4.1.1 Obtain all current available opioid overdose data.
- 4.1.2 Determine whether analysis will utilize rates or counts.
- 4.1.3 Define criteria to determine Communities of Greatest Need.
- 4.1.4 Generate updated statewide MA Opioid Overdose Profile/Report.
- 4.1.5 Identify Communities of Greatest Need and prioritize based on prevalence rates, capacity, and readiness.

Objective 4.2: Allocate resources to Communities of Greatest Need across the state to support prevention/reduction of fatal and non-fatal opioid overdoses over the next five years.

Strategies:

- 4.2.1 Allocate current opioid overdose prevention funding to communities across the Commonwealth.
- 4.2.2 Identify, coordinate, and align resources for opioid overdose prevention with other state prevention providers (or agencies).
- 4.2.3 Continue to identify and engage key local stakeholders and community champions to prevent/reduce opioid overdoses.
- 4.2.4 Increase the number of community sectors engaged in policy/practice change to prevent/reduce opioid overdoses.
- 4.2.5 Continue to identify and engage legislators to champion policy changes to prevent/reduce opioid overdoses.

Objective 4.3: Increase capacity statewide to prevent/reduce fatal and non-fatal opioid overdoses by increasing the number of communities engaged in/implementing this work over five years.

Strategies:

- 4.3.1 Develop criteria to define Communities of Greatest Need and determine funding formula based on these criteria.
- 4.3.2 Funded communities will each work with/mentor other communities (based on criteria to be outlined) to increase the number of communities engaged in this work.

4.3.3 Review current funding allocations to support subpopulations (based on identity: Native Americans, LGBTQ, etc., and based on setting: military families, college students, etc.).

4.3.4 Provide training/technical assistance to build capacity to implement and evaluate evidence-based policies, programs and strategies and/or environmental strategies based on the SPF process.

4.3.5 Continue to increase public awareness about opioid overdose prevention through public information initiatives/media campaign.

Objective 4.4: Increase community and statewide capacity to implement and sustain a SPF-based, comprehensive prevention approach that includes evidence-based policies, programs and strategies and/or environmental strategies to prevent/reduce fatal and non-fatal opioid overdoses, over five years.

Strategies:

4.4.1 Update Guidance Document to include evidence-based policies, programs and strategies and/or environmental strategies.

4.4.2 Provide training/technical assistance to all communities implementing a SPF-based, comprehensive prevention approach that includes evidence-based policies, programs and strategies and/or environmental strategies.

4.4.3 Develop a mentoring process for funded communities.

4.4.4 Create statewide training/technical assistance workgroup to support communities engaged in this work.

4.4.5 Identify and engage key community stakeholders and local champions to prevent/reduce opioid overdoses.

4.4.6 Continue to identify and engage legislators to champion policy changes to prevent/reduce opioid overdoses.

4.4.7 Continue to collaborate, coordinate and align activities with BSAS programs and other opioid overdose prevention initiatives, e.g. Narcan training, SBIRT, OBOT, SPHERE.

Objective 4.5: Evaluate the impact of statewide efforts on fatal and non-fatal opioid overdose rates over five years.

Strategies:

4.5.1 Analyze statewide data for fatal and non-fatal opioid overdoses to identify changes in rates comparing funded and non-funded communities.

4.5.2 Develop impact measures (e.g. community involvement, mentoring involvement, policy and practice changes) tool and implement with funded communities.

4.5.3 Analyze rates and results of impact assessment and apply funding to future efforts.

(D) KEY SPE DECISION MAKING PROCESSES AND FINDINGS
SPF Steps 2 & 3: CAPACITY BUILDING AND PLANNING

The first phase of work on this MSPE project consisted of an assessment process (SPF Step 1) complete with a gap analysis that culminated in the development of a "Capacity Building/ Infrastructure Enhancement Plan" (SPF Step 2, submitted in December, 2011). This plan described strengths, opportunities and gaps and delineated next steps to guide the strategic planning process.

During the course of developing this strategic plan (SPF Step 3), the Massachusetts SPE Working Group and the SPE Policy Consortium encountered a number of critical decision points at each stage of the process. This section of the document summarizes the major issues and their associated outcomes.

Prioritization Process

The identification of priority substance abuse prevention needs and related long-term and short-term consequences was based on findings from the MA Epidemiology Workgroup, as well as the updated data in the 2012 revision of the MA Epi Profile, and involved a number of decision points:

- Should the Epidemiological Profile, created as part of the SPF-SIG, be updated?
- Could the prioritization process be truncated to fit within the time constraints of the SPE and still maintain a basic level of scientific rigor?
- How would consumption patterns and expanded behavioral health issues be included in the updated profile?
- Should the process be strictly data-driven or should it be data-informed?
- What was the best way to balance existing priorities with new or emerging priorities?

Given that the original MA Epi Profile was created in March 2007, the SPE Working Group and SPE Policy Consortium representative agreed that the document should be updated. The first step in this process was to examine resources that were not available when the first Epi Profile was created. This included retrieval of documents from SAMHSA, its epidemiological contractors, the Center for the Application of Prevention Technologies (CAPT), and updated Epi Profiles from other states. The team also made extensive use of SAMHSA/CSAP's new Behavioral Health Indicator System (BHIS). Priority was placed on: (1) retrieving the most current and up-to-date data available on the indicators examined in the original profile, (2) incorporating additional behavioral health indicators that were not examined in the original profile, (3) including substance use consumption data – the original profile considered only substance abuse-related consequences, and (4) obtaining as much information as possible on special populations (i.e., Native Americans, Veterans, and Military Families).

Upon completion of the updated MA Epi Profile, the Team turned its attention to revising the data prioritization process. Using the prioritization process developed by the MA Epidemiology Workgroup as part of the SPF-SIG, the Team identified a set of new guiding principles. The goal of this activity was to adhere to the practice-based standards and rigor of the existing prioritization process, while simultaneously infusing the process with new priorities and lessons

learned. Attention was also paid to the potential implications associated with truncating a process that initially took 12-16 months into a 2-3 month time period.

The following set of guiding principles was adopted to guide and inform the updated data prioritization process:
(1) The updated Epi Profile should reflect lessons learned from the earlier prioritization process, the experience of other states, and SAMHSA/CSAP and its contractors;
(2) The prioritization process should be expanded to include consumption patterns in addition to consequences;
(3) The prioritization process should take into account and maximize coordination with *existing* plans, efforts, and priorities in the Commonwealth;
(4) The process should be data-informed; and
(5) The process should consider new and emerging issues that may not be accurately represented given limitations and availability of existing data.

The first major decision point concerned how to incorporate consumption data into the updated Epi Profile. The Team could examine consumption and consequences separately, identify consumption patterns first and then assess the associated consequences, or examine consequences first and trace them back to the associated consumption patterns. In consultation with senior epidemiologists at the Pacific Institute of Research and Evaluation (PIRE) and based on a review of the updated guidance on developing Epi Profiles, the Team decided to focus on consequences first and then trace them back to related consumption data in order to identify appropriate target population(s)/group(s). In other words, identify the most pressing public health issues and then identify the consumption patterns that most likely contribute to the occurrence of these issues.

The second decision point concerned whether the prioritization process should be strictly data-driven (i.e., purely data-based) or whether it should be data-informed (i.e., incorporate factors such as expert opinion, anecdotal data, political priorities, etc.) Based on an assessment of the data available, time-lags, data quality, lack of available data, and other issues inherent in the process, the Team decided that it should be a *data-informed process*. This decision was primarily based on the realization that relying on the existing consequence data alone would fail to describe the entire landscape and that issues may be disproportionately identified based on data availability alone rather than actual need. For example, if there were 15 alcohol-related consequences examined and only 2 marijuana-related consequences examined based on data availability, a purely data-driven process would disproportionately favor one issue simply because it had more/better data available.

The final major decision point in the prioritization process concerned how to strike an appropriate balance between the state's existing priorities and new or emerging issues. In consultation with the Massachusetts Department of Public Health (MDPH)'s Bureau of Substance Abuse Services (BSAS) and a representative from the Executive Committee of the IAC, the SPE Working Group decided to prioritize existing issues in the absence of compelling data to the contrary, and to identify a set of new and emerging issues. In other words, to

respect the ongoing work and priorities set by the state (unless the data suggested that these were no longer issues), while also identifying issues that the state should *begin* to focus on for the future rather than abruptly abandoning existing work in favor of an entirely new set of priorities.

Data Driven Goals and Objectives

Using data from the updated Epi Profile and the data prioritization process, the Team was committed to identifying data-driven goals and objectives that could be quantified, monitored, and evaluated for changes over time. Members of the SPE Working Group that participated in this process included representatives from the MA Department of Public Health's Bureau of Substance Abuse Services, the Executive Director of the IAC, representatives from the state's training and technical assistance provider, the SPE strategic consultants at HRiA, a representative from the MA Department of Public Health's Data and Statistics Unit, and a representative from the SPF-SIG state evaluation team. The final set of goals and objectives were presented to the SPE Policy Consortium and finalized on June 21, 2012. The major questions and decision points encountered were:

- What approach should be used to ensure that the goals were broad and inclusive and that the objectives were realistic and measurable?
- How should goals, objectives, and strategies be defined and operationalized?
- How could this effort align with other Department and Bureau strategic plans?
- What was the appropriate balance between programmatic, collaboration and coordination, data, and capacity-building goals and objectives?

The Team decided to utilize a rapid strategic planning process to generate the goals, objectives, and strategies. This approach consisted of a series of time-limited, face-to-face meetings with the opportunity to provide feedback and edits between meetings. Goals were defined as: (1) a projected state of affairs that a person or a system plans or intends to achieve, (2) a statement that identifies in broad terms how your initiative is going to change things in order to solve the problems you have identified, and (3) a result that one is attempting to achieve. Objectives were defined as: (1) specific statements of intended accomplishments, (2) steps that will take place in order to achieve the changes described in the goals, and (3) action-oriented phrases that further specify what the goal is trying to achieve. Strategies were defined as action-oriented phrases that describe the manner in which the objectives will be approached.

To ensure that the specified objectives could be quantified, monitored, and evaluated for changes over time, the Team adopted the Centers for Disease Control and Prevention's SMART process for developing objectives. Under this approach, each objective is designed and evaluated according to the following criteria: (1) **S**pecific – does it clearly state what will be achieved? (2) **M**easurable – is it measurable? How will you know when it is accomplished? (3) **A**chievable – is it action-oriented and attainable? (4) **R**ealistic – is it realistic with the resources available or anticipated? (5) **T**imely – when will it be achieved?

The Comprehensive Strategic Prevention Plan needs to co-exist with other plans and initiatives such as the Commonwealth of Massachusetts Substance Abuse Strategic Plan Update FY 2011 –

FY 2016. This plan and other Bureau-level materials and resources were reviewed (e.g., the Bureau's vision and mission statements) to ensure that the new comprehensive plan was consistent, complementary, and not contradictory with other guiding documents.

The last major decision point concerned how to strike an appropriate balance between programmatic, collaboration and coordination, data, and capacity-building goals and objectives. Following some early drift toward over-emphasis on the program side, the Team decided that each set of objectives within each goal should attempt to use SAMHSA's Strategic Prevention Framework (SPF) as a guiding framework. In other words, each series of objectives for each goal should be examined to determine whether assessment, capacity building, planning, implementation, evaluation, sustainability, and cultural competence were represented.

Coordinating Services with Public/Private Delivery Systems and Health Care

The coordination of services with public and private delivery systems, including primary health care, was addressed directly in Goal 2 of the Comprehensive Strategic Prevention Plan: *Goal 2: Enhance collaboration, coordination, and alignment within and among state agencies and other stakeholders, including primary health care and mental/behavioral health care, to prevent/reduce substance abuse*.

The Team decided that if any real movement was likely to occur in this important area that it needed to be formalized as a goal with a corresponding objective and set of strategies. Specifically, the first objective of Goal 2 is: *Objective 2.1: Leverage and align state-wide funding streams and resources for prevention by identifying state agencies and other stakeholders, including primary health care and mental/behavioral health care, working to prevent/reduce substance abuse*. Progress toward this objective is expected to occur as a result of: (1) surveying state agencies to identify resources (financial, programmatic, community) invested in substance abuse prevention services within 9 months of plan approval; (2) surveying non-state stakeholders, including primary health care and mental/behavioral health care to determine investment of governmental and non-governmental resources in substance abuse prevention services within one and a half years of plan approval; (3) developing an inventory of programs and funding for substance abuse prevention services among state agencies and other stakeholders, including primary health care and mental/behavioral health care within one year; and (4) highlighting existing collaborations among state agencies and other stakeholders, including primary health care and mental/behavioral health care.

The Team's decision to elevate coordination of services with public/private delivery systems and health care helps formalize what has been, to date, an informal and opportunistic process. Goal 2 of the Comprehensive Strategic Plan is intended to raise awareness among each of the stakeholders via the inventory and highlighting of existing collaborations. This increased level of awareness constitutes a first, necessary step in securing commitment and buy-in to move to a point of more coordinated and integrated planning and service delivery in the substance abuse prevention area.

Logic Model and Evidence-Based Program Selection and Implementation

The development of a state and local common logic model template and the process for selecting and implementing evidence-based programs, policies, and practices constituted one of the most significant challenges to the group. The key decision-points for this component included:

- Which logic model template should be used?
- Should the state logic model and the local logic model be the same or emphasize different factors?
- Should data be included in the logic model given that the intent is for this to be a data-driven process?
- Should the state reconstitute the ad-hoc evidence-based strategies workgroup that formed for the SPF-SIG?
- What criteria should be used to identify what constitutes an evidence-based program, policy, or practice?
- What level of support should be given to communities to assist them with implementation of both the SPF process and implementation of discrete program activities?

The logic model conversation involved a series of inter-related decision-points and spanned multiple meetings. The Team examined the state-level logic model that guides the work of the SPF-SIG initiative, the state-level logic model that guides the substance abuse prevention and treatment block grant prevention programs, the local-level logic models for both of these initiatives, the SAMHSA/CSAP planning model, and the community logic model from *Identifying and Selecting Evidence-Based Interventions* (SAMHSA, 2009).[4] Each of these potential models had pros and cons and used slightly different approaches to organize the information. For example, the SAMHSA/CSAP community logic model identifies substance abuse-related consequences, risk and protective factors/conditions, and strategies. The SPF-SIG state logic model includes substance-related consequences, substance use consumption patterns, intervening variables/risk or causal factors, and strategies/interventions. The community-level SPF-SIG logic model includes the consequence of focus, intervening variable, strategy, target group, and short-term, intermediate, and long-term outcomes.

The first decision the Team made was to retain a two-tier logic model structure – a "planning" logic model at the state-level and an "implementation" logic model at the local level. It was decided that the state-level logic model should follow the guidance and structure provided by SAMHSA/CSAP with some minor modifications. The final version of the state logic model consists of three columns: (1) consequence and/or consumption pattern(s), (2) intervening variables (risk and protective factors/causal factors), and (3) strategies and interventions (evidence-based programs, policies, and practices). Rather than attempting to populate this model with data, the Team decided to identify data sources – thus preserving the data-driven focus while still keeping the model at a fairly high level. At the local level, the Team decided to retain the implementation logic model (described above) that has been so successfully used by the SPF-SIG and block grant sub-recipient communities.

The Team identified a number of ad-hoc workgroups that the state may want to consider expanding, reinvigorating, or creating (e.g., evidence-based strategies workgroup, sustainability workgroup, training and technical assistance workgroup, etc.) BSAS has routinely convened ad-hoc evidence-based strategies workgroups since the late 1990's in response to Federal and State funding initiatives. This practice began in response to the original CSAP State Incentive Grant (SIG) and was utilized for the State's alcohol prevention program initiative and most recently for the State's State Prevention Framework – State Incentive Grant (SPF-SIG). Staffed by representatives from BSAS, researchers, prevention practitioners, and representatives from the training and technical assistance (TA) community, this workgroup has historically been tasked with identifying effective evidence-based programs, policies, and practices. The Team decided that representatives from the EBP workgroup should continue to sit on proposal review panels for State-managed prevention funding initiatives to ensure that all proposed activities meet evidence-based standards.

The criteria used to identify evidence-based programs, policies, and practices has changed and evolved over time, even within state and federal agencies. In determining what criteria the members of the evidence-based workgroup should use to define "evidence-based," the Team decided to follow the guidance provided by SAMHSA/CSAP in its *Identifying and Selecting Evidence-Based Interventions* publication (SAMHSA, 2009). As part of the SPF-SIG initiative, Massachusetts funded sub-recipient communities to prevent unintentional fatal and non-fatal opioid overdoses. The choice to focus on this consequence and the complete absence of programs, policies, and practices in Federal registries and in the peer-reviewed literature necessitated the adoption of SAMHSA/CSAP's third criteria for identifying EBPs – the use of other documentation and expert consensus. In contrast, Massachusetts block grant sub-recipient communities targeting underage drinking as an issue were required to choose programs, policies, and practices that appeared on federal registries such as NREPP – SAMHSA/CSAP's first criteria for identifying EBPs. The Team decided to recommend the use of this guidance document in the future, given its flexibility and the range of potential issues (e.g., overdose prevention, prescription drug abuse, underage drinking, marijuana prevention, etc.) that the state may focus on in the future and the relative abundance or paucity of evidence-based interventions available to address the targeted issues and groups.

The final decision point in the area of logic models, program selection, and implementation concerned the identification of structures to support and enhance statewide prevention capacity. The Team decided to address capacity needs by incorporating training and technical assistance objectives throughout the plan. For example, *Objective 3.4: Increase statewide capacity to prevent substance abuse with a focus on underage drinking by increasing the number of communities that implement and sustain a SPF-based, comprehensive prevention approach that includes evidence-based policies, programs, and strategies and/or environmental strategies, within one year*. Strategy 4.4.4 of the plan specifically calls for the creation of a statewide training/technical assistance workgroup to support communities engaged in prevention work.

Funding Formula

The last major decision area concerned the identification of an agreed-upon formula for allocating State substance abuse prevention resources to identified communities of greatest need according to data-driven, needs-based approaches. The discussion began by attempting to distill the core components of the current funding allocation process. The major questions guiding this discussion were:

- How are current funding decisions made?
- Are data on needs a part of this decision at both the state and local level?
- What role does local capacity play in current funding decisions?
- What is the minimum level of investment needed to maximize the odds of achieving positive outcomes at the local level?

The Team engaged in an in-depth discussion about how funding decisions are currently made and attempted to develop a mathematical representation of the process. For each proposed initiative, the process begins by identifying the targeted issue(s) and the resources available to distribute to localities. Based on the issue(s) identified and the goals and objectives of the initiative, a decision is made about the minimum level of investment needed to maximize the odds of achieving positive outcomes at the local level. For example, initiatives promoting the use of environmental strategies (e.g., media campaigns, social marketing, and policy change) may require fewer resources than those emphasizing more indicated levels of intervention. For most initiatives, it is desirable to fund at least one FTE staff position to help plan, coordinate, and execute the work.

Needs data are part of every funding decision and will continue to be a part of all future funding decisions. The Team noted that all Requests for Proposals summarize state-level need based on currently available data (e.g., data from the Youth Health Survey, state overdose data) and applicants are always required to provide additional local-level data to demonstrate site-specific needs. One of the major decisions that came out of the SPE Comprehensive Prevention Planning approach was to more explicitly call for the identification of gaps in resources and/or health disparities for subpopulations (based on dimensions such as identity and setting). Based on the goals and objectives of this plan, the Team anticipates greater emphasis on these factors when allocating future prevention funding.

The last major decision-point in this area was the role of capacity. The Team discussed whether capacity should be viewed as a positive or negative factor during the funding allocation process. For example, a site may have enormous need but little capacity to address the need. On the other hand, the site may have less need but a high level of capacity. The tentative solution to this question was to treat it on an initiative-by-initiative and site-by-site basis, but to build in mechanisms to capitalize on the current level of capacity in the system. Objectives 3.4 and 4.4 in the Comprehensive Prevention Plan call for the creation of mentor-mentee relationships between communities. In other words, funding sites at both ends of the capacity continuum with the expectation that higher capacity sites will assist lower capacity sites.

Implementation, Evaluation, and Action/Sustainability Plans

The implementation plan, evaluation plan, and action/sustainability plan are presented later in this document. Each of the templates used were created to flow organically from the goals and objectives and required little formal discussion. Members of the Team reviewed each template, made minor suggestions and modifications, and reviewed each final product prior to presentation to the SPE Policy Consortium members.

(E) PROCESSES, PROCEDURES AND LOGIC MODEL CRITERIA

SPF Step 3: PLANNING

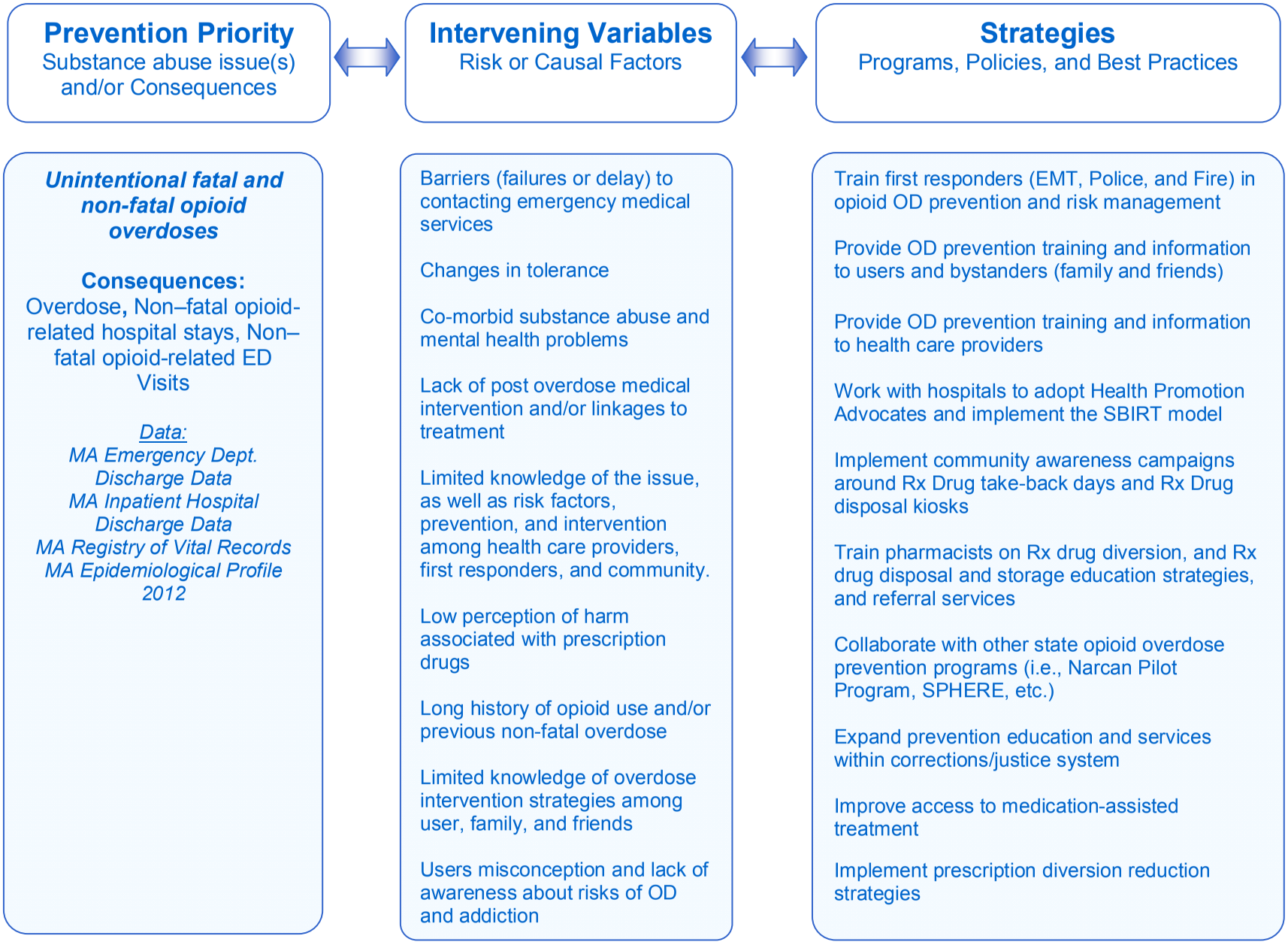
A Logic Model serves as a valuable tool to guide the planning process. The flow depicts risks and protective factors ("intervening variables") associated with a selected priority area and helps align selection of strategies with specific intervening variables and the projected outcomes. Communities funded by MDPH to prevent or reduce substance abuse and its consequences are required to choose evidence-based strategies to implement. (Criteria for identifying and selecting evidence-based strategies are further delineated below under "*Community Guidelines for Selecting Evidence-Based Strategies and Developing a Community Logic Model*: 2. Select Strategies with Evidence of Effectiveness.") MA communities funded by BSAS for prevention efforts are also required to create detailed logic models and track progress accordingly.

MA State Logic Models

Massachusetts has developed logic models for each of the two substance-specific goals of this plan: prevention of Underage Drinking (Goal 3) and prevention Fatal and Non-fatal Opioid Overdoses (Goal 4). These logic models, illustrated on the following two pages, provide an overview of each of these problems at the state level. These models identify the problem and key intervening variables/risk and protective factors that relate to the identified problem in broadly identified populations. Each intervening variable highlights an opportunity for interventions that can lead to positive outcomes in the targeted population. A list of evidence-based strategies related to the intervening variables is included in the logic models to assist the community-level planning process. Each community funded for specific activities to address Goal 3 and/or Goal 4 will tailor this logic model to its needs. (This process is described below under "*Community Guidelines for Selecting Evidence-Based Strategies and Developing a Community Logic Model.")*

For MassCALL2 communities (i.e., those funded to address prevention of intentional or unintentional opioid overdoses), BSAS developed a guidance document to assist with selection of evidence-based strategies to prevent opioid overdoses. (Note: development of this guidance document was necessitated by the complete absence of evidence-based programs, policies, and practices in Federal registries and in the peer-reviewed literature. Therefore, use of other documentation and expert consensus was required to identify promising data-informed strategies, as described in the guidance document.) The SPE Working Group decided to recommend the future use of this guidance document, given its flexibility and the range of potential issues (e.g., overdose prevention, prescription drug abuse, underage drinking, marijuana prevention, etc.) that the state may focus on in the future and the relative abundance or paucity of evidence-based interventions available to address the targeted issues.

Massachusetts Fatal and Non-Fatal Opioid Overdose Prevention Logic Model



Massachusetts Underage Drinking Prevention Logic Model

Community Logic Models

BSAS-funded communities need to develop strategic approaches to prevent/reduce substance abuse issues based on SAMHSA's Strategic Prevention Framework (SPF). For the critical planning step, BSAS created ***"Community Guidelines for Selecting Evidence-Based Strategies and Developing a Community Logic Model"*** with the following steps:

1. Prioritize Risk and Protective Factors/Intervening Variables Related to Unintentional Fatal and Non-Fatal Opioid Overdoses/Underage Drinking

One of the main reasons for conducting the needs/assets assessment (SPF Step 1) is to identify which intervening variable(s)/risk and protective factor(s) the community will focus on to prevent/reduce unintentional fatal and non-fatal opioid overdoses-/underage drinking. Once the community has identified relevant local intervening variables/risk and protective factors and collected information about them, the community needs to prioritize these variables/factors. Guidelines for prioritizing intervening variables/risk and protective factors based on quantitative and qualitative data include the following:

- Review collected quantitative and qualitative data related to the intervening variables/risk and protective factors.
- Identify the intervening variables/risk and protective factors most closely related to cases of unintentional fatal and non-fatal opioid overdoses/underage drinking in your community.
- Identify the population most impacted by these variables/risk and protective factors.
- Prioritize the identified intervening variables/risk and protective factors.

2. Select Strategies with Evidence of Effectiveness

Strategy selection is an important part of the SPF process, but no more important than the assessment and capacity-building phases. A thorough understanding of the needs, the local intervening variables, and consideration of local capacity and readiness are each essential to choosing an appropriate strategy or strategies. The SPF emphasizes the importance of strength of evidence to inform and guide intervention selection decisions. Communities must select strategies that fit into one of the 3 categories listed below. SAMHSA presents three definitions of "evidence-based" programs, as follows:

- Inclusion in Federal registries of evidence-based interventions; or
- Reported (with positive effects on the primary targeted outcome) in peer-reviewed journals; or
- Documented effectiveness supported by other sources of information and the consensus judgment of informed experts, as described in the following set of guidelines, *all of which must be met:*

  Guideline 1: The intervention is based on a theory of change that is documented in a clear logic or conceptual model; and

  Guideline 2: The intervention is similar in content and structure to interventions that appear in registries and/or the peer-reviewed literature; and

  Guideline 3: The intervention is supported by documentation that it has been effectively implemented in the past, and multiple times, in a manner attentive to scientific standards of

evidence and with results that show a consistent pattern of credible and positive effects; and

Guideline 4: The intervention is reviewed and deemed appropriate by a panel of informed prevention experts that includes: well-qualified prevention researchers who are experienced in evaluating prevention interventions similar to those under review; local prevention practitioners; and key community leaders as appropriate, e.g., officials from law enforcement and education sectors or elders within indigenous cultures.

Fatal and Non-Fatal Opioid Overdose Prevention Strategies

In comparison to areas such as alcohol and tobacco prevention, the scientific knowledge base concerning opioid overdoses is not as well developed. While a great deal of effort has been devoted to understanding risk factors and intervening variables for opioid overdose, relatively little attention has been paid to developing and studying the impact of interventions in this area. Strategies with the potential to reduce opioid overdose are more likely to be based on expert opinion than the results of formal evaluations of effectiveness. In this context, traditional guidance around strategy selection (e.g., selecting interventions from Federal lists of evidence-based prevention; multiple independent replications of an intervention) becomes difficult to follow. Given that the state of the science in this area has not yet progressed to this level, a different set of criteria needed to be adopted to guide strategy selection in as rigorous a manner as possible. To this end, the state has chosen to focus on two overarching criteria: 1) evidence of linkages between the targeted intervening variable(s) and the proposed strategy, and 2) conceptual and practical fit of the proposed strategy. Adherence to these two criteria by funded communities will help to maximize the odds that the strategy or strategies put into place as part of the current MassCALL2, or any future opioid overdose prevention initiative, will reduce the number of unintentional fatal and non-fatal opioid overdoses.

In preparation for the MassCALL2 initiative, the state, in collaboration with CSAP's Northeast Center for the Application of Prevention Technologies (CAPT), generated a list of strategies with the potential to reduce unintentional fatal and non-fatal opioid overdoses (attached here). The strategies that have already been identified are the product of a review of research literature on opioid overdoses that included contact with experts as well as searches of databases. While a number of strategies have been identified for each of the intervening variables identified by the state, this list is not meant to be exhaustive, nor is the list of intervening variables intended to be exhaustive. It may well be the case that the community's local assessment reveals additional intervening variables that are more relevant to the local community, and which require the identification of other strategies. Therefore, there is no formal requirement to adopt one of the strategies that has already been identified. The choice of strategy should be guided by the results of the local assessment, with consideration given to the intervening variable(s) that are seen as contributing to the consequence in a given community.

Underage Drinking (UAD) Prevention Strategies

Federal registries of evidence-based interventions list strategies that are effective in reducing underage drinking, including environmental strategies that focus on availability norms and regulations. Current BSAS-funded UAD communities are required to implement environmental

strategies as a primary focus of their comprehensive program design. These communities are also required to conduct and report on alcohol compliance checks with all licensed alcohol vendors in their communities at least twice a year. Communities may also implement a non – environmental evidence-based strategy, but may use no more than 25% of their overall BSAS funding to do so.

Determination of Strategy Appropriateness

In selecting an appropriate strategy to address the intervening variables identified by the community, it is important to consider evidence of effectiveness, conceptual fit, and practical fit. Communities are required to document that they have completed the following steps for each selected strategy.

Evidence of Effectiveness

Review strategies that have been identified as having the potential to affect the selected intervening variables. For each strategy:

- Identify research evidence (journal articles, unpublished research) that describes how the selected strategy is related to the selected intervening variable(s).
- Based on the cited research evidence, present a rationale (a theory of change) that describes how the strategy addresses the selected intervening variable(s).

Conceptual Fit

To determine Conceptual Fit for each strategy, communities are advised to consider the following questions:

- How has the strategy been tested with the identified target population or, if it has not, how can it be generalized to the target population?
- How will implementing this strategy in this local community help to achieve the anticipated outcomes?

Practical Fit

Communities must consider current ability to implement each of the selected strategies effectively in relation to the following categories:

- Resources (cost, staffing, access to target population, etc.)
- Collaborative/Coalition Climate (fit with existing prevention/reduction efforts, willingness to accept new programs, buy-in of key leaders, etc.)
- Community Climate (community attitude toward the strategy, buy-in of key leaders, etc.)
- Sustainability of the strategy (community ownership, renewable financial support, community champions, etc.)

Based on this analysis, communities select the strategy (or strategies) to implement to prevent/reduce unintentional fatal and non-fatal opioid overdoses and/or prevent/reduce substance abuse, particularly under-age drinking.

Submitting Selected Strategies for Approval

After identifying the selected strategy or strategies, the community must submit the information described below to the BSAS Assistant Director of Prevention Services Unit. This information will be reviewed by BSAS Prevention Services Unit.

3. Develop a Community Logic Model

The community logic model serves as a guide for planning that needs to take place to generate community level change. During the previous step, the issue for the community has been more clearly defined, the intervening variables/risk and protective factors that most impact the community have been identified and strategies have been selected. The next step is to establish measurable outcomes for each strategy.

Establish Measurable Outcomes for Each Strategy

Communities must list the anticipated short-term, intermediate, and long-term outcomes for each strategy selected.

Logic Model

Based on the information gathered in the previous steps, communities will develop a logic model that describes how the community/coalition/collaborative will address the priority intervening variable(s), along with the measurable outcomes, using the model below.

Community Logic Model Template

Substance Abuse Issue (Consumption/Consequence/etc.)					
Intervening Variable	Strategy	Target Group	Outcomes:		
			Short-Term	Intermediate	Long-Term

Identify Resources Required to Effectively Implement Strategies

To implement each selected strategy, communities need to specify all needed resources by considering the following:

- Human Resources (staffing, partnerships, volunteers, coalition membership, etc.)
- Skills (data collection and analysis, prevention/intervention knowledge and skills, etc.)
- Fiscal Resources (monetary, in-kind)
- Material Resources (space, equipment, etc.)
- Existing resource gaps that may limit ability to effectively implement the selected strategy or strategies

4. Implement Evidence –Based Strategies

BSAS has chosen EDC as the new, statewide provider of technical assistance for substance abuse prevention. Under this contract which began July 1st, EDC will direct technical assistance services in close collaboration with Bay State Community Services in Quincy and the Franklin Regional Council of Governments in Western Massachusetts.

As part of a new center to be known as the Massachusetts Technical Assistance Partnership for Prevention, or MassTAPP, EDC will provide customized assistance and support to BSAS-funded substance abuse prevention programs and other cities, towns, and local coalitions working to prevent alcohol and other drug-related problems.

EDC will draw on its experience working with dozens of school districts, service providers and communities across the country, using the most up-to-date research on prevention strategies to collaborate more effectively across systems and geographical regions. MassTAPP will employ a core team of technical assistance specialists to include experts in the reduction of underage drinking and opioid overdose (BSAS's current priorities) as well as practitioners with experience in planning and implementing alcohol, tobacco and other drugs prevention campaigns. Many of the upcoming in-person trainings and networking events will be open to anyone in the state working in the area of substance abuse prevention, in addition to the communities funded by BSAS.

This new center, charged with uniting prevention efforts across the state, will make use of cutting-edge technology to offer webinars and other distance learning events to share information and research and bring together communities with similar concerns. In addition, the new center will offer peer-to-peer learning and mentoring opportunities to encourage communities to share strategies and work together.

BSAS staff will provide guidance and support to the communities implementing substance abuse prevention strategies. BSAS Staff will visit each funded community annually to identify the community's accomplishments, understand the community's/programs strengths and needs, identify TA and training needs, and determine how the community might serve as a resource to other communities. Communities will receive TA and training to address identified needs.

(F) FORMULA FOR ALLOCATING MA SUBSTANCE ABUSE PREVENTION RESOURCES
SPF Step 3: PLANNING

Another element of the planning step is to determine distribution of funds and other resources; in this case, it includes supporting the implementation of the strategic plan goals, as well as supporting substance abuse prevention statewide.

Planning the specific allocation of substance abuse prevention funds and related resources is a complex process that must align with the goals and objectives of this strategic plan, goals and objectives of collaborating agencies, the state's strategic plan, and funder requirements. As Goal 2 of this comprehensive strategic plan calls for greater collaboration and coordination among state agencies, implementation of this goal and the associated objectives will require funding allocation processes to be **revisited regularly** as inter-agency relationships and collaborations evolve and a common formula is considered.

The myriad factors **currently considered by BSAS** when making decisions regarding state funding of substance abuse prevention activities are outlined in the narrative and graphic below. Several of these factors directly inform RFP development for funds available for community disbursement. The remaining issues are evaluated by BSAS during the proposal review and funding determination processes. Procurement and disbursement of substance abuse prevention funds takes place through the following three phases.

Phase 1: Federal funding is made available for application submittal. **Funding source dictates parameters** that determine how resources are to be used – i.e., for communities, for state infrastructure, for evaluation. BSAS makes decisions and creates a proposal based on the match of MA's needs and the state's capacities to use the funding.

Phase 2: State level application describes what is allocated to priorities determined by the RFP (what is used for state level capacity to manage the project; what is allocated to communities; what is allocated for evaluation, etc.) Award amounts may necessitate amending those allocations.

Phase 3: **Amount of available funding**, in addition to its parameters, influences allocation determinations. For funding devoted to communities, MDPH defines amounts to be put in the Community RFP based on the **needs and capacities of applicant communities**. Communities with high capacity and relatively lower need will be weighed against communities of high need with low capacity. High-need low-capacity communities will be mentored by high capacity communities to allow resources to be directed towards the greatest needs, while empowering high-capacity communities to share their skills and resources. The number and type of awards made will be impacted by the **state's capacity to manage contracts, provide technical assistance, and conduct evaluation**.

In making determinations, BSAS applies the following **principles**:

- Funding is **targeted to Communities of Greatest Need**, as **identified through a data-informed process**.

- Funding is directed to maximize the likelihood that positive change will occur in the outcomes of interest. Need may be determined by consumption and consequence rates to allow quantification of need to be calculated independent of population density.
- Allocations are data-informed using the MA Epidemiologic Profile and other sources of information to define target populations and geographies.
- All work emphasizes collaboration of cross-sector community partners and/or coalitions of involved stakeholders.
- All communities use the SPF to structure their plans for resources and impact.
- All work is done through and with local government.
- All communities are required to use evidence-based strategies.
- All communities are required to measure outcomes.
- Funding decisions take into account the level of effort required to successfully operate the grant at the local level based on the programs, policies, and/or practices put into place to address the targeted issue(s).
- Funding is based on the **likelihood that communities will be able to sustain the work** beyond the period of state funding.

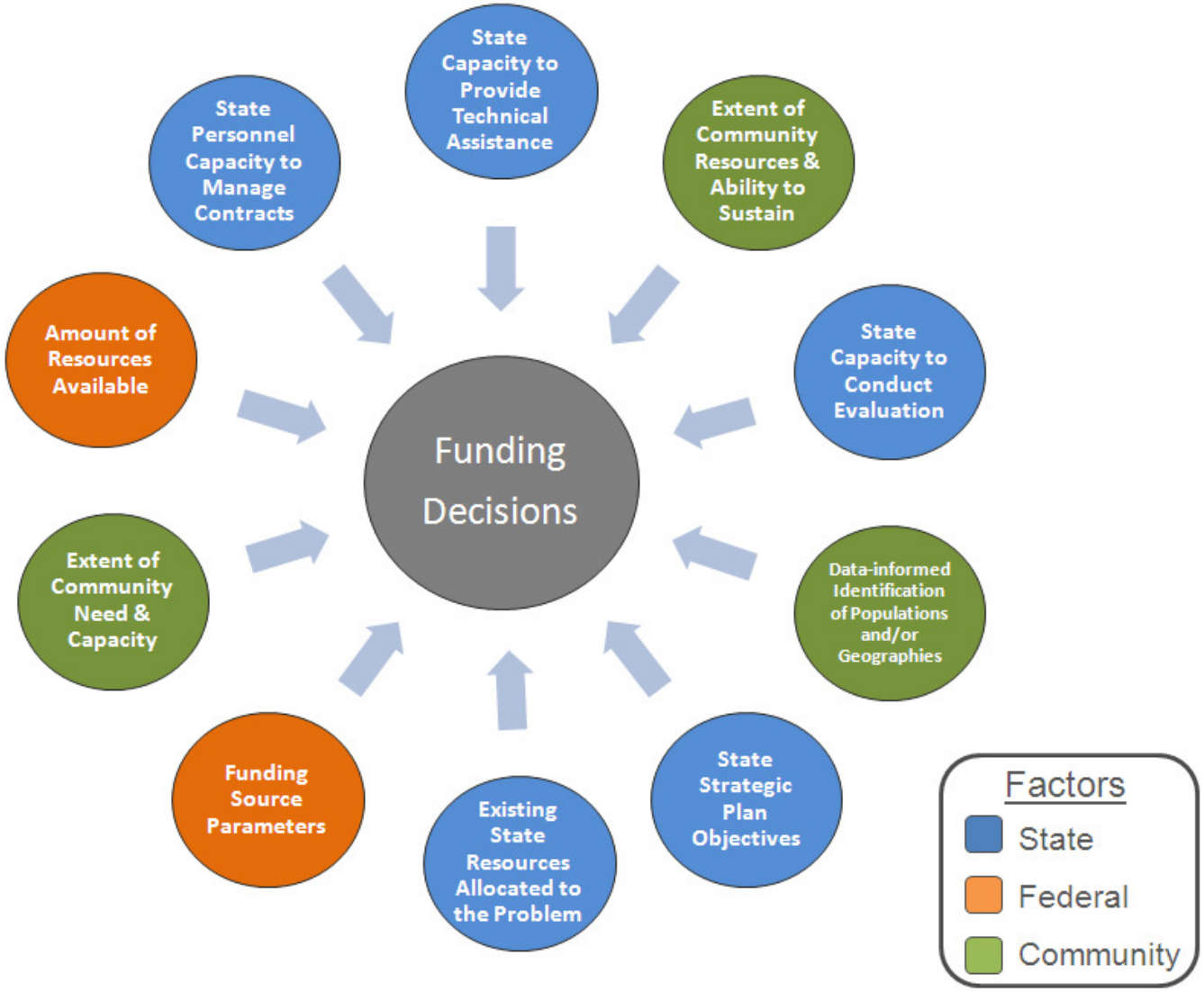
BSAS also gives strong weight to the following **considerations** when making funding determinations:

- Priority populations are given special attention during RFP development, in selection of applications, in determining award amounts, and in TA allocations.
- Funds are directed toward activities and approaches that will **promote implementation of the 5-year strategic plan**.
- **Other state resources allocated** to the issue/initiative are considered to avoid duplication of services and/or funding streams.

This describes the present situation. Currently the work in tobacco is coordinated through BSAS and shares this approach as well. Future efforts and strategic goals will move toward greater synergy among other state agencies. These principles and approaches to resource allocations for substance abuse prevention will be shared with other state agencies as the coordination process commences. The IAC will foster a collaborative approach to enable state agencies to come to consensus around a shared funding formula.

The figure below, entitled “Funding Considerations,” depicts the various factors that currently influence BSAS’ allocation of substance abuse prevention grant resources to MA communities. The color codes indicate whether each variable is a federal, state or community level factor. We expect this process to evolve as Goal 2 of this strategic plan is implemented and specific considerations of other state entities are taken into account as well.

Funding Considerations



(G) IMPLEMENTATION PLAN

SPF Step 4: IMPLEMENTATION

The Implementation phase is guided by a detailed plan listing the steps necessary to implement the evidence-based programs, practices, and policies identified through the goals, objectives and strategies that emerged from the planning phase. The Implementation Plan also depicts a 5-year timeline that identifies those responsible and the expected commencement and completion dates for each strategy. Please refer to the BSAS MSPE Implementation Plan in chart form below.

BSAS MSPE Implementation Plan

KEY: Y1 Q1 = Year 1, Quarter 1 (e.g., July, 2012 –Sept, 2012)
"v" = Ditto (continued from above)

Goal 1: Enhance the state's ability to track, monitor and report on prevention activities, substance abuse patterns, and emerging issues using all available data sources.

OBJECTIVE 1.1: Finalize BSAS web-based reporting system within six months.

Strategies	Person Responsible	Y1 Q1	Y1 Q2	Y1 Q3	Y1 Q4	Y2 Q1	Y2 Q2	Y2 Q3	Y2 Q4	Y3 Q1	Y3 Q2	Y3 Q3	Y3 Q4	Y4 Q1	Y4 Q2	Y4 Q3	Y4 Q4	Y5 Q1	Y5 Q2	Y5 Q3	Y5 Q4
Review structure of data system and provide feedback to database development team.	BSAS Prevention with IT and TA Consultants																				
Design and implement a strategy to communicate certification requirement to funded and non-funded communities.	v																				

Strategies	Person Responsible	Y1 Q1	Y1 Q2	Y1 Q3	Y1 Q4	Y2 Q1	Y2 Q2	Y2 Q3	Y2 Q4	Y3 Q1	Y3 Q2	Y3 Q3	Y3 Q4	Y4 Q1	Y4 Q2	Y4 Q3	Y4 Q4	Y5 Q1	Y5 Q2	Y5 Q3	Y5 Q4
Begin process of certifying all prevention programs (municipalities and agencies) across the Commonwealth.	v																				
Develop training manual for the reporting system.	v																				
Provide training manual to funded communities.	v																				
Finalize format of automated reports.	v																				
Review and finalize process for NOMS reporting.	v																				

Goal 1: Enhance the state's ability to track, monitor and report on prevention activities, substance abuse patterns, and emerging issues using all available data sources.

OBJECTIVE 1.2: Promote and increase data sharing among agencies within two years.

Strategies	Person Responsible	Y1 Q1	Y1 Q2	Y1 Q3	Y1 Q4	Y2 Q1	Y2 Q2	Y2 Q3	Y2 Q4	Y3 Q1	Y3 Q2	Y3 Q3	Y3 Q4	Y4 Q1	Y4 Q2	Y4 Q3	Y4 Q4	Y5 Q1	Y5 Q2	Y5 Q3	Y5 Q4
Reinvigorate MEW and expand membership.	BSAS Prevention. ODADS (Office of Data Analytics and Decision Support)																				

Strategies	Person Responsible	Y1 Q1	Y1 Q2	Y1 Q3	Y1 Q4	Y2 Q1	Y2 Q2	Y2 Q3	Y2 Q4	Y3 Q1	Y3 Q2	Y3 Q3	Y3 Q4	Y4 Q1	Y4 Q2	Y4 Q3	Y4 Q4	Y5 Q1	Y5 Q2	Y5 Q3	Y5 Q4
Activate MOU for each member of the MEW related to sharing data.	BSAS Prevention, ODADS, IAC ED																				
Identify data point of contact for data in each state agency.	v																				
Obtain clarification of data expectations from each statewide partner, involving the MEW as appropriate.	v																				
Collaborate with IAC to gain access to the most current data available from each member.	BSAS Prevention. ODADS (Office of Data Analytics and Decision Support)																				
Work within MPDH to obtain all current substance use and abuse related data available from each Office and Bureau.	v																				

Goal 1: Enhance the state's ability to track, monitor and report on prevention activities, substance abuse patterns, and emerging issues using all available data sources.

OBJECTIVE 1.3: Expand means to store, organize, and analyze inter-agency and inter-departmental substance use and abuse-related data within five years.

Strategies	Person Responsible	Y1 Q1	Y1 Q2	Y1 Q3	Y1 Q4	Y2 Q1	Y2 Q2	Y2 Q3	Y2 Q4	Y3 Q1	Y3 Q2	Y3 Q3	Y3 Q4	Y4 Q1	Y4 Q2	Y4 Q3	Y4 Q4	Y5 Q1	Y5 Q2	Y5 Q3	Y5 Q4
Build infrastructure to house collected data.	BSAS Prevention and ODADS																				
Determine how the data collected fits within the system.	v																				
Determine how to organize and report data.	v																				
Build internal capacity to analyze collected data.	v																				
Explore progress to make data more accessible to communities and stakeholders.	v																				
Update MA Epidemiologic Profile annually.	v																				

Goal 1: Enhance the state's ability to track, monitor and report on prevention activities, substance abuse patterns, and emerging issues using all available data sources.

OBJECTIVE 1.4: Develop new mechanisms to collect data to help identify Communities of High Need and emerging substance use and abuse issues, periodically.

Strategies	Person Responsible	Y1 Q1	Y1 Q2	Y1 Q3	Y1 Q4	Y2 Q1	Y2 Q2	Y2 Q3	Y2 Q4	Y3 Q1	Y3 Q2	Y3 Q3	Y3 Q4	Y4 Q1	Y4 Q2	Y4 Q3	Y4 Q4	Y5 Q1	Y5 Q2	Y5 Q3	Y5 Q4
Use work groups to review current surveillance systems.	BSAS Prevention and ODADS																				

Strategies	Person Responsible	Y1 Q1	Y1 Q2	Y1 Q3	Y1 Q4	Y2 Q1	Y2 Q2	Y2 Q3	Y2 Q4	Y3 Q1	Y3 Q2	Y3 Q3	Y3 Q4	Y4 Q1	Y4 Q2	Y4 Q3	Y4 Q4	Y5 Q1	Y5 Q2	Y5 Q3	Y5 Q4
Explore new opportunities to collect and analyze data.	v																				
Identify gaps in resources and/or health disparities for subpopulations (based on identity: Native Americans, LGBTQ, etc., and based on setting: military families, college students, etc.)	v																				
Develop new surveillance models.	v																				

Goal 2: Enhance collaboration, coordination and alignment within and among state agencies and other stakeholders, including primary health care and mental/behavioral health care, to prevent/reduce substance abuse.

OBJECTIVE 2.1: Leverage and align state-wide funding streams and resources for prevention by identifying state agencies and other stakeholders, including primary health care and mental/behavioral health care, working to prevent/reduce substance abuse.

Strategies	Person Responsible	Y1 Q1	Y1 Q2	Y1 Q3	Y1 Q4	Y2 Q1	Y2 Q2	Y2 Q3	Y2 Q4	Y3 Q1	Y3 Q2	Y3 Q3	Y3 Q4	Y4 Q1	Y4 Q2	Y4 Q3	Y4 Q4	Y5 Q1	Y5 Q2	Y5 Q3	Y5 Q4
Survey state agencies to identify resources (financial, programmatic, community) invested in substance abuse prevention services within 9 months of plan approval.	BSAS Prevention to work with IAC																				

Strategies	Person Responsible	Y1 Q1	Y1 Q2	Y1 Q3	Y1 Q4	Y2 Q1	Y2 Q2	Y2 Q3	Y2 Q4	Y3 Q1	Y3 Q2	Y3 Q3	Y3 Q4	Y4 Q1	Y4 Q2	Y4 Q3	Y4 Q4	Y5 Q1	Y5 Q2	Y5 Q3	Y5 Q4
Survey non-state stakeholders, including primary health care and mental/behavioral health care, to determine investment of governmental and nongovernmental resources in substance abuse prevention services within one and a half years of plan approval.	v																				
Develop an inventory of programs and funding for substance abuse prevention services among state agencies and other stakeholders, including primary health care and mental/behavioral health care, within one year.	v																				
Highlight existing collaborations among state agencies and other stakeholders, including primary health care and mental/behavioral health care.	v																				

Goal 2: Enhance collaboration, coordination and alignment within and among state agencies and other stakeholders, including primary health care and mental/behavioral health care, to prevent/reduce substance abuse.

OBJECTIVE 2.2: Develop strategies to enhance, coordinate, redirect and align prevention efforts among state agencies and other stakeholders, working with DMH where the priorities and populations overlap.

Strategies	Person Responsible	Y1 Q1	Y1 Q2	Y1 Q3	Y1 Q4	Y2 Q1	Y2 Q2	Y2 Q3	Y2 Q4	Y3 Q1	Y3 Q2	Y3 Q3	Y3 Q4	Y4 Q1	Y4 Q2	Y4 Q3	Y4 Q4	Y5 Q1	Y5 Q2	Y5 Q3	Y5 Q4
Share inventory of programs and funding for substance abuse prevention services among state agencies and other stakeholders with IAC.	BSAS Prevention and IAC																				
Identify opportunities for increased coordination of substance abuse prevention efforts and resources.	v																				
Identify common/shared guidelines for funding allocation among state agencies and other stakeholders.	v																				
Design a collaborative process for identifying and obtaining new funding resources.	v																				
Explore potential sources of reimbursement that may become available through health care reform.	v																				

Goal 2: Enhance collaboration, coordination and alignment within and among state agencies and other stakeholders, including primary health care and mental/behavioral health care, to prevent/reduce substance abuse.

OBJECTIVE 2.3: Develop a process to ensure prevention funding and resources target Communities of High Need (including subpopulations based on identity: Native Americans, LGBTQ, etc., and based on setting: military families, college students, etc.), based on prevalence rates and data analysis over five years.

Strategies	Person Responsible	Y1 Q1	Y1 Q2	Y1 Q3	Y1 Q4	Y2 Q1	Y2 Q2	Y2 Q3	Y2 Q4	Y3 Q1	Y3 Q2	Y3 Q3	Y3 Q4	Y4 Q1	Y4 Q2	Y4 Q3	Y4 Q4	Y5 Q1	Y5 Q2	Y5 Q3	Y5 Q4
Review all available data within a five-year period to identify Communities of High Need.	BSAS, ODADS, and IAC																				
Design a funding formula, based on available state and other stakeholder resources, that prioritizes Communities of High Need.	v																				

Goal 2: Enhance collaboration and coordination within and among state agencies and other stakeholders, including primary health care and mental/behavioral health care, to prevent/reduce substance abuse.

OBJECTIVE 2.4: Evaluate changes in collaboration and coordination within and among state agencies and other stakeholders, including primary health care and mental/behavioral health care, to prevent/reduce substance abuse.

Strategies	Person Responsible	Y1 Q1	Y1 Q2	Y1 Q3	Y1 Q4	Y2 Q1	Y2 Q2	Y2 Q3	Y2 Q4	Y3 Q1	Y3 Q2	Y3 Q3	Y3 Q4	Y4 Q1	Y4 Q2	Y4 Q3	Y4 Q4	Y5 Q1	Y5 Q2	Y5 Q3	Y5 Q4
Design and implement an evaluation to capture changes in collaboration and coordination.	BSAS Prevention and External Consultant																				

Goal 3: Prevent/Reduce substance abuse with a continued focus on underage drinking.

Objective 3.1: Identify communities of greatest need based on most current statewide data, every three years.

Strategies	Person Responsible	Y1 Q1	Y1 Q2	Y1 Q3	Y1 Q4	Y2 Q1	Y2 Q2	Y2 Q3	Y2 Q4	Y3 Q1	Y3 Q2	Y3 Q3	Y3 Q4	Y4 Q1	Y4 Q2	Y4 Q3	Y4 Q4	Y5 Q1	Y5 Q2	Y5 Q3	Y5 Q4
Obtain all current available substance abuse-related consumption and consequence data with a focus on underage drinking.	BSAS Prevention, ODADS																				
Define criteria to determine Communities of Greatest Need.	v																				
Generate updated statewide MA Epi Profile.	v																				
Identify Communities of Greatest Need and prioritize based on prevalence rates, capacity, and readiness.	v																				

Goal 3: Prevent/Reduce substance abuse with a continued focus on underage drinking.

Objective 3.2: Allocate resources to Communities of Greatest Need across the state to support the prevention/reduction of substance abuse and/or underage drinking over the next five years.

Strategies	Person Responsible	Y1 Q1	Y1 Q2	Y1 Q3	Y1 Q4	Y2 Q1	Y2 Q2	Y2 Q3	Y2 Q4	Y3 Q1	Y3 Q2	Y3 Q3	Y3 Q4	Y4 Q1	Y4 Q2	Y4 Q3	Y4 Q4	Y5 Q1	Y5 Q2	Y5 Q3	Y5 Q4
Apply for relevant grants.	BSAS Prevention and IAC members																				

Strategies	Person Responsible	Y1 Q1	Y1 Q2	Y1 Q3	Y1 Q4	Y2 Q1	Y2 Q2	Y2 Q3	Y2 Q4	Y3 Q1	Y3 Q2	Y3 Q3	Y3 Q4	Y4 Q1	Y4 Q2	Y4 Q3	Y4 Q4	Y5 Q1	Y5 Q2	Y5 Q3	Y5 Q4
Identify, coordinate, and align resources for substance abuse prevention with other state prevention providers (or agencies).	v																				
Continue to identify and engage key community stakeholders and local community champions to prevent/reduce underage drinking.	v																				
Increase the number of community sectors engaged in policy/practice change to prevent/reduce underage drinking.	v																				
Continue to identify and engage legislators to champion policy changes to prevent/reduce underage drinking.	IAC members and BSAS leadership																				

Goal 3: Prevent/Reduce substance abuse with a continued focus on underage drinking.

Objective 3.3: Increase capacity statewide to prevent/reduce substance abuse and/or underage drinking by increasing the number of communities engaged in/implementing this work over five years.

Strategies	Person Responsible	Y1 Q1	Y1 Q2	Y1 Q3	Y1 Q4	Y2 Q1	Y2 Q2	Y2 Q3	Y2 Q4	Y3 Q1	Y3 Q2	Y3 Q3	Y3 Q4	Y4 Q1	Y4 Q2	Y4 Q3	Y4 Q4	Y5 Q1	Y5 Q2	Y5 Q3	Y5 Q4
Implement prevention certification process with interested communities.	BSAS Prevention and TA consultant																				

Strategies	Person Responsible	Y1 Q1	Y1 Q2	Y1 Q3	Y1 Q4	Y2 Q1	Y2 Q2	Y2 Q3	Y2 Q4	Y3 Q1	Y3 Q2	Y3 Q3	Y3 Q4	Y4 Q1	Y4 Q2	Y4 Q3	Y4 Q4	Y5 Q1	Y5 Q2	Y5 Q3	Y5 Q4
Integrate the Strategic Prevention Framework as a planning model in all funded programs and communities, and offer training/technical assistance on the SPF process.	v																				
Reassess funding based on performance and/or reach/impact annually.	v																				
Explore mentoring relationships within and among clusters.	v																				

Goal 3: Prevent/Reduce substance abuse with a continued focus on underage drinking.

Objective 3.4: Increase statewide capacity to prevent/reduce substance abuse with a focus on underage drinking by increasing the number of communities that implement and sustain a SPF-based, comprehensive prevention approach that includes evidence-based policies, programs and strategies and/or environmental strategies, within one year.

Strategies	Person Responsible	Y1 Q1	Y1 Q2	Y1 Q3	Y1 Q4	Y2 Q1	Y2 Q2	Y2 Q3	Y2 Q4	Y3 Q1	Y3 Q2	Y3 Q3	Y3 Q4	Y4 Q1	Y4 Q2	Y4 Q3	Y4 Q4	Y5 Q1	Y5 Q2	Y5 Q3	Y5 Q4
Use the BSAS certification process to increase the number of communities using a SPF-based, comprehensive prevention approach that includes evidence-based policies, programs and strategies and/or environmental strategies.	v																				

Strategies	Person Responsible	Y1 Q1	Y1 Q2	Y1 Q3	Y1 Q4	Y2 Q1	Y2 Q2	Y2 Q3	Y2 Q4	Y3 Q1	Y3 Q2	Y3 Q3	Y3 Q4	Y4 Q1	Y4 Q2	Y4 Q3	Y4 Q4	Y5 Q1	Y5 Q2	Y5 Q3	Y5 Q4
Provide T/TA to communities and non-geographic communities to build capacity to acquire prevention funding.	v																				
Provide T/TA to build capacity to implement and evaluate evidence-based policies, programs and strategies and/or environmental strategies based on the SPF process.	v																				
Continue to increase public awareness about underage drinking through public information initiatives/media campaign.	BSAS																				

Goal 3: Prevent/Reduce substance abuse with a continued focus on underage drinking.

Objective 3.5: Evaluate the impact of statewide efforts on substance abuse and underage drinking within one year

Strategies	Person Responsible	Y1 Q1	Y1 Q2	Y1 Q3	Y1 Q4	Y2 Q1	Y2 Q2	Y2 Q3	Y2 Q4	Y3 Q1	Y3 Q2	Y3 Q3	Y3 Q4	Y4 Q1	Y4 Q2	Y4 Q3	Y4 Q4	Y5 Q1	Y5 Q2	Y5 Q3	Y5 Q4
Ensure that all BSAS prevention activities are evaluated.	BSAS Prevention and ODADS																				
Perform YRBS data analysis in-house for trends and for comparison with other communities.	v																				
Look at archival data for trends.	v																				

Strategies	Person Responsible	Y1 Q1	Y1 Q2	Y1 Q3	Y1 Q4	Y2 Q1	Y2 Q2	Y2 Q3	Y2 Q4	Y3 Q1	Y3 Q2	Y3 Q3	Y3 Q4	Y4 Q1	Y4 Q2	Y4 Q3	Y4 Q4	Y5 Q1	Y5 Q2	Y5 Q3	Y5 Q4
Require funded communities to submit evaluation data (with core measures).	BSAS																				

Goal 4: Prevent/Reduce fatal and non-fatal opioid overdoses.

Objective 4.1: Identify Communities of Greatest Need based on all current statewide opioid overdose data, every three years.

Strategies	Person Responsible	Y1 Q1	Y1 Q2	Y1 Q3	Y1 Q4	Y2 Q1	Y2 Q2	Y2 Q3	Y2 Q4	Y3 Q1	Y3 Q2	Y3 Q3	Y3 Q4	Y4 Q1	Y4 Q2	Y4 Q3	Y4 Q4	Y5 Q1	Y5 Q2	Y5 Q3	Y5 Q4
Obtain all current available opioid overdose data.	BSAS, ODADS, MDPH Data Office																				
Determine whether analysis will utilize rates or counts.	v																				
Define criteria to determine Communities of Greatest Need.	v																				
Generate updated statewide MA Opioid Overdose Profile.	v																				
Identify Communities of Greatest Need and prioritize based on prevalence rates, capacity, and readiness.	v																				

Goal 4: Prevent/Reduce fatal and non-fatal opioid overdoses.

Objective 4.2: Allocate resources to Communities of Greatest Need across the state to support prevention/reduction of fatal and non-fatal opioid overdoses over the next five years.

Strategies	Person Responsible	Y1 Q1	Y1 Q2	Y1 Q3	Y1 Q4	Y2 Q1	Y2 Q2	Y2 Q3	Y2 Q4	Y3 Q1	Y3 Q2	Y3 Q3	Y3 Q4	Y4 Q1	Y4 Q2	Y4 Q3	Y4 Q4	Y5 Q1	Y5 Q2	Y5 Q3	Y5 Q4
Allocate current opioid overdose prevention funding to communities across the Commonwealth.	BSAS Prevention																				
Identify, coordinate, and align resources for substance abuse prevention with other state prevention providers (or agencies).	BSAS Prevention and IAC																				
Continue to identify and engage key community stakeholders and local community champions to prevent/reduce opioid overdose.	BSAS and funded communities																				
Increase the number of community sectors engaged in policy/practice change to prevent/reduce opioid overdose.	v																				
Continue to identify and engage legislators to champion policy changes to prevent/reduce opioid overdose.	v																				

Goal 4: Prevent/Reduce fatal and non-fatal opioid overdoses.

Objective 4.3: Increase capacity statewide to prevent/reduce fatal and non-fatal opioid overdoses by increasing the number of communities engaged in/implementing this work over five years.

Strategies	Person Responsible	Y1 Q1	Y1 Q2	Y1 Q3	Y1 Q4	Y2 Q1	Y2 Q2	Y2 Q3	Y2 Q4	Y3 Q1	Y3 Q2	Y3 Q3	Y3 Q4	Y4 Q1	Y4 Q2	Y4 Q3	Y4 Q4	Y5 Q1	Y5 Q2	Y5 Q3	Y5 Q4
Develop criteria to define Communities of Greatest Need and determine funding formula based on these criteria.	BSAS Prevention and ODAS																				
Funded communities will each work with/mentor other communities (based on criteria to be outlined) to increase the number of communities engaged in this work.	BSAS, TA Consultant and Communities																				
Review current funding allocations to support subpopulations (based on identity: Native Americans, LGBTQ, etc., and based on setting: military families, college students, etc.)	BSAS Prevention and ODAS																				
Provide T/TA to build capacity to implement and evaluate evidence-based policies, programs and strategies and/or environmental strategies based on the SPF process.	BSAS and TA Consultant																				
Continue to increase public awareness about opioid overdose prevention through public information initiatives/media campaign.	BSAS																				

Goal 4: Prevent/Reduce fatal and non-fatal opioid overdoses.

Objective 4.4: Increase community and statewide capacity to sustain a SPF-based, comprehensive prevention approach that includes evidence-based policies, programs and strategies and/or environmental strategies to prevent/reduce fatal and non-fatal opioid overdoses, over five years.

Strategies	Person Responsible	Y1 Q1	Y1 Q2	Y1 Q3	Y1 Q4	Y2 Q1	Y2 Q2	Y2 Q3	Y2 Q4	Y3 Q1	Y3 Q2	Y3 Q3	Y3 Q4	Y4 Q1	Y4 Q2	Y4 Q3	Y4 Q4	Y5 Q1	Y5 Q2	Y5 Q3	Y5 Q4
Update guidance document to include evidence-based policies, programs and strategies and/or environmental strategies.	BSAS Prevention and TA Consultant	DONE																			
Provide T/TA to all communities implementing a SPF-based, comprehensive prevention approach that includes evidence-based policies, programs and strategies and/or environmental strategies.	v																				
Develop a mentoring process for funded communities.	v																				
Create statewide T/TA workgroup to support communities engaged in this work.	v																				
Identify and engage key community stakeholders and local champions to prevent/reduce opioid overdoses.	BSAS and Communities																				
Continue to identify and engage legislators to champion policy changes to prevent/reduce opioid overdoses.	v																				

Strategies	Person Responsible	Y1 Q1	Y1 Q2	Y1 Q3	Y1 Q4	Y2 Q1	Y2 Q2	Y2 Q3	Y2 Q4	Y3 Q1	Y3 Q2	Y3 Q3	Y3 Q4	Y4 Q1	Y4 Q2	Y4 Q3	Y4 Q4	Y5 Q1	Y5 Q2	Y5 Q3	Y5 Q4
Continue to collaborate, coordinate and align activities with BSAS programs and other opioid overdose prevention initiatives, e.g. Narcan training, SBIRT, OBOT, SPHERE.	v																				

Goal 4: Prevent/Reduce fatal and non-fatal opioid overdoses.

Objective 4.5: Evaluate the impact of statewide efforts on fatal and non-fatal opioid overdose rates over five years.

Strategies	Person Responsible	Y1 Q1	Y1 Q2	Y1 Q3	Y1 Q4	Y2 Q1	Y2 Q2	Y2 Q3	Y2 Q4	Y3 Q1	Y3 Q2	Y3 Q3	Y3 Q4	Y4 Q1	Y4 Q2	Y4 Q3	Y4 Q4	Y5 Q1	Y5 Q2	Y5 Q3	Y5 Q4
Analyze statewide data for fatal and non-fatal opioid overdoses to identify changes in rates comparing funded and non-funded communities.	BSAS Prevention, ODADS, and external consultant																				
Develop impact measures (e.g. community involvement, mentoring involvement, policy and practice changes) tool and implement with funded communities.	v																				
Analyze rates and results of impact assessment and apply funding to future efforts.	v																				

(H) BSAS SPF-SPE EVALUATION PLAN

SPF Step 5: EVALUATION

Step 5 of the SPF entails creation of an evaluation plan that identifies baseline and outcomes data as well as processes and procedures for conducting an evaluation, and describes how needs assessment and evaluation data will be used for ongoing adjustments. This section of the Comprehensive Strategic Prevention Plan describes ways in which the Commonwealth may want to consider evaluating the four goals identified by this project and/or a more limited set of discrete goals, objectives, or strategies. This section is not intended to be exhaustive of all of the potential evaluation designs and measures that could be employed. Rather, the purpose of this section is to highlight and propose some key indicators of progress. BSAS, in collaboration with its partners, will need to identify the resources it plans to devote to evaluative activities and how these resources should be allocated across goals, objectives, and/or strategies implemented over the next five years at both the state and community levels.

GOAL 1: Enhance the state's ability to track, monitor, and report on prevention activities, substance abuse patterns, and emerging issues using all available data sources

The first goal of the SPE Comprehensive Strategic Prevention Plan is to enhance the state's ability to track, monitor, and report on prevention activities, substance abuse patterns, and emerging issues using all available data sources.

- Outcome Evaluation Question G.1.1. How, and to what extent, has the state's ability to track, monitor, and report on prevention activities, substance abuse patterns, and emerging issues using all available data sources changed between baseline and 5-years post-implementation of the Comprehensive Strategic Prevention Plan?

- Outcome Evaluation Question G.1.2. What factors facilitated and impeded the state's ability to successfully track, monitor, and report on prevention activities, substance abuse patterns, and emerging issues using all available data sources?

Data for answering the two goal-based evaluation questions are largely descriptive in nature. In addition to the process and outcome evaluation data identified for the Goal 1 objectives and strategies that follow, BSAS may want to consider periodically tracking and documenting changes in its data infrastructure and changes in its internal capacity to track, monitor, and report on prevention activities, substance abuse patterns, and emerging issues.

Potential data sources include: (a) notes and minutes from internal planning meetings related to data capacity; (b) changes in staffing patterns and FTEs devoted to data capacity; (c) changes in policies and practices, and their results; (d) new reports or briefs on substance abuse patterns and emerging issues and the manner in which they were generated; and (e) interviews with Department and Bureau heads to describe changes, catalysts, and barriers/deterrents.

Using the SMART approach pioneered by the U.S. Centers for Disease Control and Prevention (CDC), each objective in the SPE Comprehensive Strategic Prevention Plan is designed to be **S**pecific, **M**easureable, **A**chievable, **R**elevant, and **T**ime-bound.

The four objectives associated with Goal 1 are:

- **Objective 1.1: Finalize BSAS web-based reporting system within six months.**

- **Objective 1.2: Promote and increase data sharing among agencies within two years.**

- **Objective 1.3: Expand means to store, organize, and analyze inter-departmental substance use and abuse-related data within five years.**

- **Objective 1.4: Develop new mechanisms to collect data to help identify Communities of High Need and emerging substance use and abuse issues, periodically.**

The successful attainment of these four objectives is intended to directly contribute to progress toward meeting the first goal of the SPE Comprehensive Strategic Prevention Plan. Each objective has an associated outcome evaluation question.

Objective 1.1: Finalize BSAS web-based reporting system within six months.

- Outcome Evaluation Question O.1.1. Is the BSAS web-based reporting system for tracking, monitoring, and reporting on community-level prevention activities finalized and fully operational within six months of implementation of the Comprehensive Strategic Prevention Plan?

Data for answering Outcome Evaluation Question O.1.1 flow directly from the collection of process evaluation questions related to the strategies put into place as part of Objective 1.1. Specifically, how many programs are certified in the new data system and how many are actively submitting data (including NOMS) into this system. Additional metrics could include: (a) the number and type of reports generated out of the database and (b) evidence of infusion of database generated reports into Bureau planning meetings as documented in notes and minutes.

Each objective in the SPE Comprehensive Strategic Prevention Plan includes a list of strategies that are intended to contribute to the completion of the objective. While it is possible to identify one or more process evaluation questions for each of the strategies identified under each objective, this document highlights only one or two potential measures per objective.

This approach was adopted for several reasons. First, not every strategy/step per each objective should be given equal weight. Some strategies and activities are conceptually more important than others in helping to meet the overarching objective. Some strategies and activities are additive in nature (i.e., have a number of pre-requisite steps before they can be undertaken or accomplished). In the case of the latter, tracking the last in a series of steps/activities implicitly identifies whether or not earlier steps in the process were

accomplished. Second, tracking every single strategy in the same manner is often not the most efficient use of limited evaluation resources.

Objective 1.1: Finalize BSAS web-based reporting system within six months.

- **Strategy 1.1.1: Review structure of data system and provide feedback to database development team.**

- **Strategy 1.1.2: Design and implement a strategy to communicate certification requirement to funded and non-funded communities.**

- **Strategy 1.1.3: Begin process of certifying all prevention programs (municipalities and agencies) across the Commonwealth.**

- **Strategy 1.1.4: Develop training manual for the reporting system and provide to all funded programs.**

- **Strategy 1.1.5: Finalize format of all automated reports.**

- **Strategy 1.1.6: Review and finalize process for NOMS reporting.**

  - Process Evaluation Question S.1.1.1. How many months does it take to finalize the new web-based reporting system?

  - Process Evaluation Question S.1.1.3. How many funded and non-funded communities are prevention certified between baseline and 5-years post-implementation of the Comprehensive Strategic Prevention Plan?

  - Process Evaluation Question S.1.1.6. How many funded communities submit prevention activity data (including NOMS data) between baseline and 5-years post-implementation of the Comprehensive Strategic Prevention Plan?

Process data for documenting the strategies put into place under Objective 1.1 can be drawn from the new BSAS web-based reporting system. These data may include: (a) the number of prevention-certified funded and non-funded programs and (b) the number of funded programs submitting prevention activity and NOMS data. These two process indicators highlight the success of the system at reaching and engaging service providers and influence the state's ability to efficiently fulfill its federal reporting requirements.

Data for strategy 1.1.1. (*review structure of data system and provide feedback to database development team*) can be tracked and documented through database development team meeting notes, minutes, and milestones. Supporting information can also be extracted on major decision points, the final set of database data fields and their purpose, the number and

type of reports programmed into the database, and factors that facilitated or impeded development.

Objective 1.2: Promote and increase data sharing among agencies within two years.

- Outcome Evaluation Question O.1.2.a. What actions were taken to promote data sharing among agencies?

- Outcome Evaluation Question O.1.2.b. Has data sharing among state agencies increased within two years of implementation of the Comprehensive Strategic Prevention Plan?

- Outcome Evaluation Question O.1.2.c. Has access to the most current substance use and abuse related data improved between BSAS, each MEW member, and other Offices and Bureaus within MDPH?

Objective 1.2 has at least three distinct components: (1) an outreach and coordination component, (2) a data sharing component, and (3) a data-lag component. The first element can be captured using descriptive data such as meeting minutes and interviews/discussions with BSAS data personnel. The purpose of this exercise would be to identify the breadth of efforts to promote data sharing among agencies. The latter questions could be answered by assessing the existing nature and degree of data sharing at baseline in comparison to a future point in time. For example, what new datasets is the Bureau examining over time, does the Bureau have access to the most current data available and what is the time-lag associated with obtaining these data, and does the Bureau share its own datasets more widely over time?

Objective 1.2: Promote and increase data sharing among agencies within two years.

- **Strategy 1.2.1: Reinstitute Massachusetts Epidemiological Workgroup (MEW) and expand membership.**

- **Strategy 1.2.2: Activate Memorandum of Understanding (MOU) for each member of the MEW related to sharing data.**

- **Strategy 1.2.3: Identify point of contact for data in each state agency.**

- **Strategy 1.2.4: Obtain clarification of data expectations from each statewide partner, involving the MEW as appropriate.**

- **Strategy 1.2.5: Collaborate with the Governor's Interagency Council (IAC) to gain access to the most current data available from each member.**

- **Strategy 1.2.6: Work within MDPH to obtain all current substance use and abuse related data available from each Office and Bureau.**

- Process Evaluation Question S.1.2.1.a. How many individuals actively participate on the MEW between baseline and 5-years post-implementation of the Comprehensive Strategic Prevention Plan?

- Process Evaluation Question S.1.2.1.b. How many different agencies, organizations, and stakeholders actively participate on the MEW between baseline and 5-years post-implementation of the Comprehensive Strategic Prevention Plan?

- Process Evaluation Question S.1.2.2. What proportion of MEW members have an active data sharing MOU filed between baseline and 5-years post-implementation of the Comprehensive Strategic Prevention Plan?

- Process Evaluation Question S.1.2.4. Are data sharing expectations clarified and formalized between state agencies and within the Offices and Bureaus at MDPH?

Process data for documenting the strategies put into place under Objective 1.2 can be drawn from MEW records and the existence and content of data sharing agreements. These data may include: (a) the number of MEW participants and their affiliation from attendance records, (b) the number and content of MOUs, and (c) documents or communication formalizing data sharing expectations between agencies and within the Offices and Bureaus at MDPH.

Objective 1.3: Expand means to store, organize, and analyze inter-departmental substance use and abuse-related data within five years.

- Outcome Evaluation Question O.1.3.a. Has BSAS expanded its means to store inter-departmental substance use and abuse-related data between baseline and 5-years post-implementation of the Comprehensive Strategic Prevention Plan?

- Outcome Evaluation Question O.1.3.b. Has BSAS expanded its means to organize inter-departmental substance use and abuse-related data between baseline and 5-years post-implementation of the Comprehensive Strategic Prevention Plan?

- Outcome Evaluation Question O.1.3.c. Has BSAS expanded its means to analyze inter-departmental substance use and abuse-related data between baseline and 5-years post-implementation of the Comprehensive Strategic Prevention Plan?

As with the previous objective, Objective 1.3 is a multi-component objective. It is possible that BSAS may have differential success at storing, organizing, and analyzing data over time based on a variety of factors. Potential data sources include: (a) notes and minutes from internal planning meetings related to the Bureau's capacity to store, organize, and analyze inter-departmental substance use and abuse-related data; (b) changes in staffing patterns and FTEs; (c) contracts with external sub-contractors or data analysts; (d) records of changes in electronic infrastructure; and (e) interviews with Department and Bureau data representatives to describe changes, catalysts, and barriers/deterrents.

Objective 1.3: Expand means to store, organize, and analyze inter-departmental substance use and abuse-related data within five years.

- **Strategy 1.3.1: Build infrastructure to house collected data.**
- **Strategy 1.3.2: Determine how the data collected fits within the system.**
- **Strategy 1.3.3: Determine how to organize and report data.**
- **Strategy 1.3.4: Build internal capacity to analyze collected data.**
- **Strategy 1.3.5: Explore progress to make data more accessible to communities and stakeholders.**
- **Strategy 1.3.6: Update MA Epidemiological Profile annually.**

  - Process Evaluation Question S.1.3.1. What is the nature and amount of resources (human, fiscal, in-kind) devoted to building data infrastructure to house collected data?

  - Process Evaluation Question S.1.3.3. How many new data reports and products are generated between baseline and 5-years post-implementation of the Comprehensive Strategic Prevention Plan?

  - Process Evaluation Question S.1.3.4. What is the nature and amount of resources (human, fiscal, in-kind) devoted to building internal capacity to analyze collected data and how has this changed between baseline and 5-years post-implementation of the Comprehensive Strategic Prevention Plan?

  - Process Evaluation Question S.1.3.5.a. How often and in what form does BSAS share data with communities and stakeholders (e.g., community profiles) and what is the nature (content) of the data shared?

  - Process Evaluation Question S.1.3.5.b. Has the amount of data BSAS shares with communities and stakeholders changed between baseline and 5-years post-implementation of the Comprehensive Strategic Prevention Plan?

  - Process Evaluation Question S.1.3.6. Has BSAS, the MEW, or its designee updated the MA Epidemiological Profile annually each year between baseline and 5-years post-implementation of the Comprehensive Strategic Prevention Plan?

Process data for documenting the strategies put into place under Objective 1.3 can be obtained from the following sources: (a) BSAS financial records; (b) interviews with Department and Bureau data representatives; (c) copies of reports, briefs, and other data products that are

pushed out to communities and stakeholders; and (d) copies of updates to the MA Epidemiological Profile that occur after 2012.

Objective 1.4: Develop new mechanisms to collect data to help identify Communities of High Need and emerging substance use and abuse issues, periodically.

- Outcome Evaluation Question O.1.4. Has BSAS developed new mechanisms to collect data to help identify Communities of High Need and emerging substance use and abuse issues between baseline and 5-years post-implementation of the Comprehensive Strategic Prevention Plan?

Data for answering Outcome Evaluation Question O.1.4 can come directly from BSAS departmental records. The data could include: (a) records of new data collection initiatives, (b) collection and review of special reports identifying gaps in resources and/or health disparities for subpopulations, and (c) data workgroup notes and minutes.

Objective 1.4: Develop new mechanisms to collect data to help identify Communities of High Need and emerging substance use and abuse issues, periodically.

- **Strategy 1.4.1: Use work groups to review current surveillance systems.**

- **Strategy 1.4.2: Explore new opportunities to collect and analyze data.**

- **Strategy 1.4.3: Identify gaps in resources and/or health disparities for subpopulations (based on identity: Native Americans, LGBTQ, etc., and based on setting: military families, college students, etc.).**

- **Strategy 1.4.4: Develop new surveillance models.**

  - Process Evaluation Question S.1.4.1. How many new data review workgroups are formed between baseline and 5-years post-implementation of the Comprehensive Strategic Prevention Plan? What is their purpose? What is their duration?

  - Process Evaluation Question S.1.4.3. How many new data reports and products are generated between baseline and 5-years post-implementation of the Comprehensive Strategic Prevention Plan that identify gaps in resources and/or health disparities for subpopulations?

  - Process Evaluation Question S.1.4.4. How many new surveillance models are developed between baseline and 5-years post-implementation of the Comprehensive Strategic Prevention Plan? What is their purpose?

Process data for documenting the strategies put into place under Objective 1.4 can be obtained from the following sources: (a) data review workgroup records; (b) collection and review of

special reports identifying gaps in resources and/or health disparities for subpopulations; and (c) documentation of new surveillance models.

GOAL 2: Enhance collaboration, coordination, and alignment within and among state agencies and other stakeholders, including primary health care and mental/behavioral health care, to prevent/reduce substance abuse.

- Outcome Evaluation Question G.2.1. How, and to what extent, has collaboration, coordination, and alignment to prevent/reduce substance abuse changed between baseline and 5-years post-implementation of the Comprehensive Strategic Prevention Plan ***within*** state agencies?

- Outcome Evaluation Question G.2.2. How, and to what extent, has collaboration, coordination, and alignment to prevent/reduce substance abuse changed between baseline and 5-years post-implementation of the Comprehensive Strategic Prevention Plan ***between*** state agencies and other stakeholders?

- Outcome Evaluation Question G.2.3. How, and to what extent, has collaboration, coordination, and alignment to prevent/reduce substance abuse increased between baseline and 5-years post-implementation of the Comprehensive Strategic Prevention Plan between state agencies, primary health care, and mental/behavioral health care?

Data for answering the three goal-based evaluation questions can come from a mixture of records data, survey data, and interview data. Potential data sources include: (a) notes, minutes, and attendance forms from the MA Interagency Council on Substance Abuse and Prevention (IAC); (b) annual IAC Council reports filed by the Executive Director of the IAC; (c) periodic (e.g., bi-annual) surveys of IAC members; and (d) interviews and structured conversations with the Executive Director of the IAC to describe changes, catalysts, and barriers/deterrents to enhanced collaboration, coordination, and alignment.

The four objectives associated with Goal 2 are:

- **Objective 2.1: Leverage and align state-wide funding streams and resource for prevention by identifying state agencies and other stakeholders, including primary health care and mental/behavioral health care, working to prevent/reduce substance abuse.**

- **Objective 2.2: Develop strategies to enhance, coordinate, redirect, and align prevention efforts among state agencies and other stakeholders, working with DMH where the priorities and populations overlap.**

- **Objective 2.3: Develop a process to ensure prevention funding and resources include Communities of High Need (including subpopulations based on identity: Native Americans, LGBTQ, etc., and based on setting: military families, college students, etc.), based on prevalence rates and data analysis over five years.**

- **Objective 2.4: Evaluate changes in collaboration and coordination within and among state agencies and other stakeholders, including primary health care and mental/behavioral health care, to prevent/reduce substance abuse.**

Objective 2.1: Leverage and align state-wide funding streams and resources for prevention by identifying state agencies and other stakeholders, including primary health care and mental/behavioral health care, working to prevent/reduce substance abuse.

- Outcome Evaluation Question O.2.1.a. Has there been any change in the leveraging and alignment of state-wide funding streams and resources to prevent/reduce substance abuse as a result of identifying state agencies and other stakeholders, including primary health care and mental/behavioral health care between baseline and 5-years post-implementation of the Comprehensive Strategic Prevention Plan?

- Outcome Evaluation Question O.2.1.b. How many state agencies and other stakeholders, including primary health care and mental/behavioral health care providers, have aligned funding and resources to prevent/reduce substance abuse between baseline and 5-years post-implementation of the Comprehensive Strategic Prevention Plan?

Data for answering the outcome evaluation questions related to Objective 2.1 can come from multiple sources including: (a) review of inventories of programs and funding for substance abuse prevention services among state agencies and other stakeholders, including primary health care and mental/behavioral health care, (b) memoranda of agreement or other documents describing how and in what way substance abuse prevention funds or resources will be leveraged or aligned, (c) meeting minutes, notes, and annual reports from the IAC, and (d) interviews and structured discussions with the Executive Director of the IAC.

Objective 2.1: Leverage and align state-wide funding streams and resources for prevention by identifying state agencies and other stakeholders, including primary health care and mental/behavioral health care, working to prevent/reduce substance abuse.

- **Strategy 2.1.1: Survey state agencies to identify resources (financial, programmatic, community) invested in substance abuse prevention services within 9 months of plan approval.**

- **Strategy 2.1.2: Survey non-state stakeholders, including primary health care and mental/behavioral health care, to determine investment of governmental and nongovernmental resources in substance abuse prevention services within one and a half years of plan approval.**

- **Strategy 2.1.3: Develop an inventory of programs and funding for substance abuse prevention services among state agencies and other stakeholders, including primary health care and mental/behavioral health care, within one year.**

- **Strategy 2.1.4: Highlight existing collaborations among state agencies and other stakeholders, including primary health care and mental/behavioral health care.**
  - Process Evaluation Question S.2.1.1. How many state agencies participate in the survey of resources invested in substance abuse prevention services?

  - Process Evaluation Question S.2.1.2. How many non-state stakeholders, including primary health care and mental/behavioral health care, participate in the survey of governmental and nongovernmental resources invested in substance abuse prevention services?

  - Process Evaluation Question S.2.1.3. How many substance abuse prevention programs are there among state agencies and other stakeholders, including primary health care and mental/behavioral health care, and at what level of funding?

  - Process Evaluation Question S.2.1.4. What collaborations exist among state agencies and other stakeholders, including primary health care and mental/behavioral health care and how do these change/grow over time?

Process data for documenting the strategies put into place under Objective 2.1 can be obtained from the following sources: (a) resource survey evaluation plan, (b) resource survey findings, and (c) interviews and structured discussions with the Executive Director of the IAC and with other state and non-state representatives and stakeholders.

Objective 2.2: Develop strategies to enhance, coordinate, redirect and align prevention efforts among state agencies and other stakeholders, working with DMH where the priorities and populations overlap.

- Outcome Evaluation Question O.2.2.a. Has there been any change in the coordination and alignment of prevention efforts among state agencies and other stakeholders between baseline and 5-years post-implementation of the Comprehensive Strategic Prevention Plan?

- Outcome Evaluation Question O.2.2.b. What strategies have been put in place to enhance, coordinate, redirect, and align prevention efforts among state agencies and other stakeholders between baseline and 5-years post-implementation of the Comprehensive Strategic Prevention Plan?

Data for answering the outcome evaluation questions related to Objective 2.2 can come from multiple sources including: (a) meeting minutes, notes, and annual reports from the IAC, (b) interviews and structured discussions with the Executive Director of the IAC, and (c) minutes and materials from meetings where common/shared guidelines for funding allocation or collaborative processes for identifying and obtaining new funding resources are discussed.

Objective 2.2: Develop strategies to enhance, coordinate, redirect and align prevention efforts among state agencies and other stakeholders, working with DMH where the priorities and populations overlap.

- **Strategy 2.2.1: Share inventory of programs and funding for substance abuse prevention services among state agencies and other stakeholders with IAC.**

- **Strategy 2.2.2: Identify opportunities for increased coordination of substance abuse prevention efforts and resources.**

- **Strategy 2.2.3: Identify common/shared guidelines for funding allocation among state agencies and other stakeholders.**

- **Strategy 2.2.4: Design a collaborative process for identifying and obtaining new funding resources.**

- **Strategy 2.2.5: Explore potential sources for reimbursement that may become available through health care reform.**
  - Process Evaluation Question S.2.2.2. What, if any, opportunities are identified for increased coordination of substance abuse prevention efforts and resources?

  - Process Evaluation Question S.2.2.3. What common/shared guidelines, if any, were created for funding allocation among state agencies and other stakeholders?

  - Process Evaluation Question S.2.2.4. What, if any, collaborative processes are developed for identifying and obtaining new funding resources?

Process data for documenting the strategies put into place under Objective 2.2 can be obtained from: (a) minutes and notes of meetings where strategies to enhance, coordinate, redirect, and align prevention efforts are discussed, (b) formal agreements or guidelines that are developed, and (c) interviews and structured discussions with the Executive Director of the IAC and with other state and non-state representatives and stakeholders.

Objective 2.3: Develop a process to ensure prevention funding and resources include Communities of High Need (including subpopulations based on identity: Native Americans, LGBTQ, etc., and based on setting: military families, college students, etc.), based on prevalence rates and data analysis over five years.

- Outcome Evaluation Question O.2.3.a. Is there a process in place to ensure prevention funding and resources target Communities of High Need by 5-years post-implementation of the Comprehensive Strategic Prevention Plan?

- Outcome Evaluation Question O.2.3.b. Has there been any change in the amount and proportion of prevention funding and resources targeting Communities of High Need between baseline and 5-years post-implementation of the Strategic Prevention Plan?

Data for answering the outcome evaluation questions related to Objective 2.3 can come from multiple sources including: (a) meeting minutes, notes, and materials generated by the group responsible for developing a prevention funding and resource allocation process, (b) prevention funding and resource data, and (c) interviews and structured discussions with the Executive Director of the IAC and representatives from agencies and organizations that fund prevention.

Objective 2.3: Develop a process to ensure prevention funding and resources target Communities of High Need (including subpopulations based on identity: Native Americans, LGBTQ, etc., and based on setting: military families, college students, etc.), based on prevalence rates and data analysis over five years.

- **Strategy 2.3.1: Review all available data within a five-year period to identify Communities of High Need.**

- **Strategy 2.3.2: Design a funding formula, based on available state and other stakeholder resources, that prioritizes Communities of High Need.**
  - Process Evaluation Question S.2.3.1. Which data sources are reviewed to identify Communities of High Need?

  - Process Evaluation Question S.2.3.2. What is the process by which the state develops a new funding formula? How does this formula prioritize Community of High Need?

Process data for documenting the strategies put into place under Objective 2.3 can be obtained from: (a) minutes and notes of meetings where funding formula decisions are discussed, (b) a description of the new funding formula, and (c) notes on the methods used to access, analyze, and review data on Communities of High Need.

Objective 2.4: Evaluate changes in collaboration and coordination within and among state agencies and other stakeholders, including primary health care and mental/behavioral health care, to prevent/reduce substance abuse.

- Outcome Evaluation Question O.2.4. Has BSAS evaluated changes in collaboration and coordination within and among state agencies and other stakeholders, including primary health care and mental/behavioral health care, to prevent/reduce substance abuse need by 5-years post-implementation of the Comprehensive Strategic Prevention Plan?

Objective 2.4. Evaluate changes in collaboration and coordination within and among state agencies and other stakeholders, including primary health care and mental/behavioral health care, to prevent/reduce substance abuse.

- **Strategy 2.4.1: Design and implement an evaluation tool to capture changes in collaboration and coordination.**
  - Process Evaluation Question S.2.4.1. Is there an evaluation tool for tracking changes in collaboration and coordination?

This objective will be tracked based on the development of a tool, collection of data, and filing of evaluation reports documenting changes in collaboration and coordination.

GOAL 3: Prevent/Reduce substance abuse with a continued focus on underage drinking

- Outcome Evaluation Question G.3.1. Has there been a significant change in underage drinking measures (e.g., age of onset, lifetime use, current use, binge drinking), including intervening variables, at the state level between baseline and 5-years post-implementation of the Comprehensive Strategic Prevention?

- Outcome Evaluation Question G.3.2. Has there been a significant change in underage drinking measures (e.g., age of onset, lifetime use, current use, binge drinking), including intervening variables, at the state level in comparison to national data between baseline and 5-years post-implementation of the Comprehensive Strategic Prevention?

- Outcome Evaluation Question G.3.3. Has there been a significant change in underage drinking measures (e.g., age of onset, lifetime use, current use, binge drinking), including intervening variables, at the local level in funded communities in comparison to the rest of the state between baseline and 5-years post-implementation of the Comprehensive Strategic Prevention?

Data for answering the three goal-based evaluation questions can come from a mixture of local, state, and national data sources such as local administrations of the Youth Risk Behavior Survey (YRBS), core measures, the state YRBS, the state Youth Health Survey (YHS), the national YRBS, the Monitoring the Future (MTF) study, and the National Survey on Drug Use and Health (NSDUH).

The five objectives associated with Goal 3 are:

- **Objective 3.1: Identify communities of greatest need based on most current statewide data, every three years.**

- **Objective 3.2: Allocate resources to Communities of Greatest Need across the state to support the prevention/reduction of substance abuse and/or underage drinking over the next five years.**

- **Objective 3.3: Increase capacity statewide to prevent/reduce substance abuse and/or underage drinking by increasing the number of communities engaged in/implementing this work over five years.**

- **Objective 3.4: Increase statewide capacity to prevent/reduce substance abuse with a focus on underage drinking by increasing the number of communities that implement and sustain a SPF-based, comprehensive prevention approach that includes evidence-based policies, programs, and strategies and/or environmental strategies, within one year.**

- **Objective 3.5: Evaluate the impact of statewide efforts on substance abuse and underage drinking within one year.**

Objective 3.1: Identify communities of greatest need based on most current statewide data, every three years.

- Outcome Evaluation Question O.3.1. How has the state operationalized, prioritized, and identified communities of greatest need based on factors such as prevalence rates, capacity, and readiness? What are the advantages and disadvantages of this process?

Data for answering this question can come from multiple sources including: (a) a review of the final identification and prioritization process, (b) meeting minutes and notes from the prioritization planning group, and (c) interviews and structured discussions with the Executive Director of the IAC and representatives from BSAS.

Objective 3.1: Identify communities of greatest need based on most current statewide data, every three years.

- **Strategy 3.1.1: Obtain all current available substance abuse-related consumption and consequence data with a focus on underage drinking.**

- **Strategy 3.1.2: Define criteria to determine Communities of Greatest Need.**

- **Strategy 3.1.3: Generate updated statewide MA Epi Profile.**

- **Strategy 3.1.4: Identify Communities of Greatest Need and prioritize based on prevalence rates, capacity, and readiness.**
  - Process Evaluation Question S.3.1.1. What steps did the state use to obtain all current available substance abuse-related consumption and consequence data with a focus on underage drinking?

  - Process Evaluation Question S.3.1.2. What criteria did the state adopt to define Communities of Greatest Need?

  - Process Evaluation Question S.3.1.3. Has BSAS, the MEW, or its designee updated the MA Epidemiological Profile annually each year between baseline and 5-years post-implementation of the Comprehensive Strategic Prevention Plan?

  - Process Evaluation Question S.3.1.4. How many Communities of Greatest Need is the state funding and what are the characteristics of these communities?

Process data for documenting the strategies put into place under Objective 3.1 can be obtained from the following sources: (a) notes and minutes from the MEW and from meetings where communities of greatest need are discussed, (b) copies of updates to the MA Epidemiological

Profile that occur after 2012, (c) state prevention funding records, and (d) the BSAS web-based reporting system.

Objective 3.2: Allocate resources to Communities of Greatest Need across the state to support the prevention/reduction of substance abuse and/or underage drinking over the next five years.

- Outcome Evaluation Question O.3.2. What level of support (fiscal and other) has the state allocated to Communities of Greatest Need across the state to prevent/reduce substance abuse and/or underage drinking between baseline and 5-years post-implementation of the Comprehensive Strategic Prevention?

Data for answering this question can come from: (a) BSAS financial records, (b) the BSAS web-based reporting system, and (c) review of inventories of programs and funding for substance abuse prevention services among state agencies and other stakeholders, including primary health care and mental/behavioral health care.

Objective 3.2: Allocate resources to Communities of Greatest Need across the state to support the prevention/reduction of substance abuse and/or underage drinking over the next five years.

- **Strategy 3.2.1: Apply for relevant grants.**

- **Strategy 3.2.2: Identify, coordinate, and align resources for substance abuse prevention with other state prevention providers (or agencies).**

- **Strategy 3.2.3: Continue to identify and engage key community stakeholders and local champions to prevent/reduce underage drinking.**

- **Strategy 3.2.4: Increase the number of community sectors engaged in policy/practice change to prevent/reduce underage drinking.**

- **Strategy 3.2.5: Continue to identify and engage legislators to champion policy changes to prevent/reduce underage drinking.**
  - Process Evaluation Question S.3.2.1. What grants has the state identified and applied for and how many of these grants are funded?

  - Process Evaluation Question S.3.2.2. What, if any, opportunities are identified for increased coordination, coordination, and alignment of substance abuse prevention efforts and resources with other state prevention providers (or agencies)?

  - Process Evaluation Question S.3.2.4. How many community sectors are engaged in policy/practice change to prevent/reduce underage drinking?

- Process Evaluation Question S.3.2.5. How many policy changes are proposed to prevent/reduce underage drinking and what is their nature?

Process data for documenting the strategies put into place under Objective 3.2 can be obtained from the following sources: (a) BSAS records, (b) minutes and notes of meetings where strategies to identify, coordinate, and align prevention resources and efforts are discussed, (c) interviews and structured discussions with the Executive Director of the IAC and with other state and non-state representatives and stakeholders, (d) the BSAS web-based reporting system, and (e) review of proposed statewide policy changes.

Objective 3.3: Increase capacity statewide to prevent/reduce substance abuse and/or underage drinking by increasing the number of communities engaged in/implementing this work over five year.

- Outcome Evaluation Question O.3.3. How many communities are engaged in or implementing efforts to prevent/reduce substance abuse and/or underage drinking at 5-years post-implementation of the Comprehensive Strategic Prevention in comparison to baseline?

Data for answering this question can come from: (a) BSAS financial records, (b) the BSAS web-based reporting system, and (c) review of inventories of programs and funding for substance abuse prevention services among state agencies and other stakeholders, including primary health care and mental/behavioral health care.

Objective 3.3: Increase capacity statewide to prevent/reduce substance abuse and/or underage drinking by increasing the number of communities engaged in/implementing this work over five years.

- **Strategy 3.3.1: Implement prevention certification process with interested communities.**

- **Strategy 3.3.2: Integrate the Strategic Prevention Framework as a planning model in all funded programs and communities, and offer training/technical assistance on SPF process.**

- **Strategy 3.3.3: Reassess funding based on performance and/or reach/impact annually.**

- **Strategy 3.3.4: Explore mentoring relationships within and among community clusters.**
  - Process Evaluation Question S.3.3.1. How many communities and programs become prevention certified via the BSAS online system?

  - Process Evaluation Question S.3.3.2.a. How many funded communities have adopted the SPF process?

  - Process Evaluation Question S.3.3.2.b. How many training and technical assistance services are delivered that address elements of the SPF?

- Process Evaluation Question S.3.3.4. How many mentoring relationships are formed?

Process data for documenting the strategies put into place under Objective 3.3 can be obtained from the following sources: (a) BSAS records, (b) the BSAS web-based reporting system, and (c) training and TA delivery records.

Objective 3.4: Increase statewide capacity to prevent/reduce substance abuse with a focus on underage drinking by increasing the number of communities that implement and sustain a SPF-based, comprehensive prevention approach that includes evidence-based policies, programs and strategies and/or environmental strategies, within one year.

- Outcome Evaluation Question O.3.4. How many communities are implementing a SPF-based, comprehensive prevention approach that includes evidence-based policies, programs, and strategies and/or environmental strategies at one-year post-implementation of the Comprehensive Strategic Prevention in comparison to baseline?

- Outcome Evaluation Question O.3.4. How many communities are sustaining a SPF-based, comprehensive prevention approach that includes evidence-based policies, programs, and strategies and/or environmental strategies at 5-years post-implementation of the Comprehensive Strategic Prevention in comparison to baseline?

Data for answering this question can come from: (a) the BSAS web-based reporting system, (b) narrative progress reports from funded communities, and (c) program site visit reports on sustainability.

Objective 3.4: Increase statewide capacity to prevent/reduce substance abuse with a focus on underage drinking by increasing the number of communities that implement and sustain a SPF-based, comprehensive prevention approach that includes evidence-based policies, programs and strategies and/or environmental strategies, within one year.

- **Strategy 3.4.1: Use the BSAS certification process to increase the number of communities using a SPF-based, comprehensive approach that includes evidence-based policies, programs, and strategies and/or environmental strategies.**

- **Strategy 3.4.2: Provide training/technical assistance to communities and non-geographic communities to build capacity to acquire prevention funding.**

- **Strategy 3.4.3: Provide training/technical assistance to build capacity to implement and evaluate evidence-based policies, programs, and strategies and/or environmental strategies based on the SPF process.**

- **Strategy 3.4.4: Continue to increase public awareness about underage drinking through public information initiatives/media campaign.**

- Process Evaluation Question S.3.4.1. How many BSAS prevention certified communities are using a SPF-based, comprehensive approach?

- Process Evaluation Question S.3.4.2. How many training and technical assistance services are delivered that are intended to build capacity to acquire prevention funding?

- Process Evaluation Question S.3.4.3. How many training and technical assistance services are delivered that are intended to build capacity to implement and evaluate evidence-based policies, programs, and strategies and/or environmental strategies based on the SPF process?

- Process Evaluation Question S.3.4.4. How many public information initiatives/media campaigns on underage drinking are delivered? How many individuals are exposed to these initiatives/media campaigns?

Process data for documenting the strategies put into place under Objective 3.3 can be obtained from the following sources: (a) BSAS records, (b) the BSAS web-based reporting system, (c) training and TA delivery records, and (d) descriptive information on public information initiatives/media campaigns.

Objective 3.5: Evaluate the impact of statewide efforts on substance abuse and underage drinking within one year.

- Outcome Evaluation Question O.3.5. Has BSAS evaluated the impact of statewide efforts on substance abuse and underage drinking within one year post-implementation of the Comprehensive Strategic Prevention Plan and ongoing?

Objective 3.5: Evaluate the impact of statewide efforts on substance abuse and underage drinking within one year.

- **Strategy 3.5.1: Ensure all BSAS prevention efforts are evaluated..**

- **Strategy 3.5.2: Perform YRBS data analysis in-house for trends and for comparison with other communities.**

- **Strategy 3.5.3: Look at archival data for trends.**

- **Strategy 3.5.4: Require funded communities to submit evaluation data (with core measures).**
  - Process Evaluation Question S.3.5.1. Has BSAS identified a plan to evaluate its efforts?

  - Process Evaluation Question S.3.5.4. Have funded communities submitted evaluation data (including core measures)?

This objective will be tracked based on BSAS' ability to identify and work with evaluators on the development of an evaluation plan, conduct an outcome evaluation of statewide efforts on substance abuse and underage drinking, and the compliance of funded communities in submitting evaluation data (including core measure data).

GOAL 4: Prevent/Reduce fatal and non-fatal opioid overdoses

- Outcome Evaluation Question G.4.1. Has there been a significant change in fatal and non-fatal opioid overdoses, including intervening variables, at the state level between baseline and 5-years post-implementation of the Comprehensive Strategic Prevention?

- Outcome Evaluation Question G.4.2. Has there been a significant change in fatal and non-fatal opioid overdoses, including intervening variables, at the local level in funded communities in comparison to the rest of the state between baseline and 5-years post-implementation of the Comprehensive Strategic Prevention?

Data for answering the three goal-based evaluation questions can come from outpatient and inpatient hospital discharge data (non-fatal) and from death certificate data (fatal).

The five objectives associated with Goal 4 are:

- **Objective 4.1: Identify Communities of Greatest Need based on all current statewide opioid overdose data, every three years.**

- **Objective 4.2: Allocate resources to Communities of Greatest Need across the state to support the prevention/reduction of fatal and non-fatal opioid overdoses over the next five years.**

- **Objective 4.3: Increase capacity statewide to prevent/reduce fatal and non-fatal opioid overdoses by increasing the number of communities engaged in/implementing this work over five years.**

- **Objective 4.4: Increase community and statewide capacity to implement and sustain a SPF-based, comprehensive prevention approach that includes evidence-based policies, programs, and strategies and/or environmental strategies to prevent/reduce fatal and non-fatal opioid overdoses, over five years.**

- **Objective 4.5: Evaluate the impact of statewide efforts on fatal and non-fatal opioid overdose rates over five years.**

Objective 4.1: Identify communities of greatest need based on all current statewide opioid overdose data, every three years.

- Outcome Evaluation Question O.4.1. How has the state operationalized, prioritized, and identified communities of greatest need based on factors such as prevalence rates, capacity, and readiness? What are the advantages and disadvantages of this process?

Data for answering this question can come from multiple sources including: (a) a review of the final identification and prioritization process, (b) meeting minutes and notes from the prioritization planning group, and (c) interviews and structured discussions with the Executive Director of the IAC and representatives from BSAS.

Objective 4.1: Identify communities of greatest need based on all current statewide opioid overdose data, every three years.

- **Strategy 4.1.1: Obtain all current available opioid overdose data.**

- **Strategy 4.1.2: Determine whether analysis will utilize rates or counts.**

- **Strategy 4.1.3: Define criteria to determine Communities of Greatest Need.**

- **Strategy 4.1.4: Generate updated statewide MA Opioid Overdose Profile/Report.**

- **Strategy 4.1.5: Identify Communities of Greatest Need and prioritize based on prevalence rates, capacity, and readiness.**
  - Process Evaluation Question S.4.1.1. What steps did the state use to obtain all current available opioid overdose data?

  - Process Evaluation Question S.4.1.2. What were the decision points that led to the adoption of rates or counts for examining overdose data?

  - Process Evaluation Question S.4.1.3. What criteria did the state adopt to define Communities of Greatest Need?

  - Process Evaluation Question S.4.1.4. Has BSAS, the MEW, or its designee updated the MA Opioid Overdose Profile/Report?

  - Process Evaluation Question S.4.1.5. How many Communities of Greatest Need is the state funding and what are the characteristics of these communities?

Process data for documenting the strategies put into place under Objective 4.1 can be obtained from the following sources: (a) notes and minutes from the MEW and from meetings where communities of greatest need are discussed, (b) copies of updates to the MA Opioid Overdose Profile/Report that occur after 2012, (c) state prevention funding records, and (d) the BSAS web-based reporting system.

Objective 4.2: Allocate resources to Communities of Greatest Need across the state to support prevention/reduction of fatal and non-fatal opioid overdoses over the next five years.

- Outcome Evaluation Question O.4.2. What level of support (fiscal and other) has the state allocated to Communities of Greatest Need across the state to prevent/reduce fatal and non-fatal opioid overdoses between baseline and 5-years post-implementation of the Comprehensive Strategic Prevention?

Data for answering this question can come from: (a) BSAS financial records, (b) the BSAS web-based reporting system, and (c) review of inventories of programs and funding for opioid overdose work among state agencies and other stakeholders, including primary health care and mental/behavioral health care.

Objective 4.2: Allocate resources to Communities of Greatest Need across the state to support prevention/reduction of fatal and non-fatal opioid overdoses over the next five years.

- **Strategy 4.2.1: Allocate current opioid overdose prevention funding to communities across the Commonwealth.**

- **Strategy 4.2.2: Identify, coordinate, and align resources for opioid overdose prevention with other state prevention providers (or agencies).**

- **Strategy 4.2.3: Continue to identify and engage key local stakeholders and community champions to prevent/reduce opioid overdoses.**

- **Strategy 4.2.4: Increase the number of community sectors engaged in policy/practice change to prevent/reduce opioid overdoses.**

- **Strategy 4.2.5: Continue to identify and engage legislators to champion policy changes to prevent/reduce opioid overdoses.**
  - Process Evaluation Question S.4.2.1. What communities has the state identified and funded for opioid overdose prevention?

  - Process Evaluation Question S.4.2.2. What, if any, opportunities are identified for increased coordination and alignment of opioid overdose prevention efforts and resources with other state prevention providers (or agencies)?

  - Process Evaluation Question S.4.2.4. How many community sectors are engaged in policy/practice change to prevent/reduce opioid overdoses?

  - Process Evaluation Question S.4.2.5. How many policy changes are proposed to prevent/reduce opioid overdoses and what is their nature?

Process data for documenting the strategies put into place under Objective 4.2 can be obtained from the following sources: (a) BSAS records, (b) minutes and notes of meetings where strategies to identify, coordinate, and align opioid overdose prevention resources and efforts

are discussed, (c) interviews and structured discussions with the Executive Director of the IAC and with other state and non-state representatives and stakeholders, (d) the BSAS web-based reporting system, and (e) review of proposed statewide policy changes.

Objective 4.3: Increase capacity statewide to prevent/reduce fatal and non-fatal opioid overdoses by increasing the number of communities engaged in/implementing this work over five years.

- Outcome Evaluation Question O.4.3. How many communities are engaged in or implementing efforts to prevent/reduce opioid overdoses at 5-years post-implementation of the Comprehensive Strategic Prevention in comparison to baseline?

Data for answering this question can come from: (a) BSAS financial records, (b) the BSAS web-based reporting system, and (c) review of inventories of programs and funding for opioid overdose prevention services among state agencies and other stakeholders, including primary health care and mental/behavioral health care.

Objective 4.3: Increase capacity statewide to prevent/reduce fatal and non-fatal opioid overdoses by increasing the number of communities engaged in/implementing this work over five years.

- **Strategy 4.3.1: Develop criteria to define Communities of Greatest Need and determine funding formula based on these criteria.**

- **Strategy 4.3.2: Funded communities will each work with/mentor other communities (based on criteria to be outlined) to increase the number of communities engaged in this work.**

- **Strategy 4.3.3: Review current funding allocations to support subpopulations ((based on identity: Native Americans, LGBTQ, etc., and based on setting: military families, college students, etc.).**

- **Strategy 4.3.4: Provide training/technical assistance to build capacity to implement and evaluate evidence-based policies, programs and strategies and/or environmental strategies based on the SPF process.**

- **Strategy 4.3.5: Continue to increase public awareness about opioid overdose prevention through public information initiatives/media campaign.**
  - Process Evaluation Question S.4.3.1. What criteria do the state use to determine Communities of Greatest Need and what funding formula is adopted?

  - Process Evaluation Question S.4.3.2. How many mentor and mentee communities are funded?

- Process Evaluation Question S.4.3.4. How many training and technical assistance services are delivered that address elements of the SPF?

- Process Evaluation Question S.4.3.5. How many public information initiatives/media campaigns on opioid overdose prevention are delivered? How many individuals are exposed to these initiatives/media campaigns?

Process data for documenting the strategies put into place under Objective 4.3 can be obtained from the following sources: (a) BSAS records, (b) the BSAS web-based reporting system, (c) training and TA delivery records, (d) descriptive information on public information initiatives/media campaigns, and (e) minutes and notes of meetings where defining communities of highest need and funding allocations are discussed.

Objective 4.4: Increase community and statewide capacity to implement and sustain a SPF-based, comprehensive prevention approach that includes evidence-based policies, programs and strategies and/or environmental strategies to prevent/reduce fatal and non-fatal opioid overdoses, over five years.

- Outcome Evaluation Question O.4.4. How many communities are implementing a SPF-based, comprehensive prevention approach that includes evidence-based policies, programs, and strategies and/or environmental strategies at 5-years post-implementation of the Comprehensive Strategic Prevention in comparison to baseline?

- Outcome Evaluation Question O.4.4. How many communities are sustaining a SPF-based, comprehensive prevention approach that includes evidence-based policies, programs, and strategies and/or environmental strategies at 5-years post-implementation of the Comprehensive Strategic Prevention in comparison to baseline?

Data for answering this question can come from: (a) the BSAS web-based reporting system, (b) narrative progress reports from funded communities, and (c) program site visit reports on sustainability.

Objective 4.4: Increase community and statewide capacity to implement and sustain a SPF-based, comprehensive prevention approach that includes evidence-based policies, programs and strategies and/or environmental strategies to prevent/reduce fatal and non-fatal opioid overdoses, over five years.

- **Strategy 4.4.1: Update Guidance Document to include evidence-based policies, programs, and strategies and/or environmental strategies.**

- **Strategy 4.4.2: Provide training/technical assistance to all communities implementing a SPF-based, comprehensive prevention approach that includes evidence-based policies, programs, and strategies and/or environmental strategies.**

- **Strategy 4.4.3: Develop a mentoring process for funded communities.**

- **Strategy 4.4.4: Create statewide training/technical assistance workgroup to support communities engaged in this work.**

- **Strategy 4.4.5: Identify and engage key community stakeholders and local champions to prevent/reduce opioid overdoses.**

- **Strategy 4.4.6: Continue to identify and engage legislators to champion policy changes to prevent/reduce opioid overdoses.**

- **Strategy 4.4.7: Continue to collaborate, coordinate, and align activities with BSAS programs and other opioid overdose prevention initiatives (e.g., Narcan training, SBIRT, OBOT, SPHERE).**
  - Process Evaluation Question S.4.4.1. Is the Guidance Document updated to include evidence-based policies, programs, and strategies and/or environmental strategies? How many new strategies are identified?

  - Process Evaluation Question S.4.4.2. How many training and technical assistance services are delivered that address implementation?

  - Process Evaluation Question S.4.4.3. How many mentor and mentee communities are funded and what does the mentoring process look like?

  - Process Evaluation Question S.4.4.4. How often does the state training/technical assistance workgroup meet, who are its members, and what does it produce?

  - Process Evaluation Question S.4.4.6. How many policy changes are proposed to prevent/reduce opioid overdoses and what is their nature?

Process data for documenting the strategies put into place under Objective 3.3 can be obtained from the following sources: (a) BSAS records, (b) the BSAS web-based reporting system, (c) training and TA delivery records, (d) review of the updated Guidance Document, (e) notes and minutes from the statewide training/technical assistance workgroup, (f) review of proposed statewide policy changes.

Objective 4.5: Evaluate the impact of statewide efforts on fatal and non-fatal opioid overdose rates over five years.

- Outcome Evaluation Question O.3.5. Has BSAS evaluated the impact of statewide efforts on fatal and non-fatal opioid overdoses within 5-years post-implementation of the Comprehensive Strategic Prevention Plan and ongoing?

Objective 4.5: Evaluate the impact of statewide efforts on fatal and non-fatal opioid overdose rates over five years.

- **Strategy 4.5.1: Analyze statewide data for fatal and non-fatal opioid overdoses to identify changes in rates comparing funded and non-funded communities.**

- **Strategy 4.5.2: Develop impact measures (e.g., community involvement, mentoring involvement, policy and practice changes) tool and implement with funded communities.**

- **Strategy 4.5.3: Analyze rates and results of impact assessment and apply funding to future efforts.**
  - Process Evaluation Question S.4.5.2. Has a tool been developed to measure the work being conducted in funded communities?

This objective will be tracked based on BSAS ability to identify and hire an evaluator, development of an evaluation plan, conduct an outcome evaluation of statewide efforts on reducing fatal and non-fatal opioid overdose rates, and the compliance of funded communities in submitting evaluation data (including core measure data).

QUALITY IMPROVEMENT, INCORPORATION OF NEEDS/EVALUATION DATA, AND REPORTING

BSAS has a strong track record of utilizing evaluation findings about its services to inform project management activities and guide ongoing improvements to its delivery system. The evaluation of the elements of the Comprehensive Strategic Prevention Plan should continue this practice through the collection of detailed information about lessons learned, barriers that inhibited implementation, how such barriers were overcome, and what should be done differently to improve service and planning activities.

Data should be reported at appropriate intervals to improve decision-making, strengthen program performance, and provide accountability. For example, reports on service activity should be generated periodically and shared with BSAS staff, evaluation should be an agenda topic at a representative subset of staff meetings, and, periodically, the evaluators should conduct oral data presentations to all staff members. In addition, the evaluators should generate data reports and white papers drawing from multiple data sources as implementation issues are identified. Evaluation presentations and reports should be written in a style that is understandable to readers who have little or no previous training in research methods, but they should include the necessary methodological details to meet the needs of a scientific audience.

Feeding ongoing needs assessment and evaluation data back into the planning and service delivery process should be an utmost priority. The evaluation should facilitate data-informed and data-driven decision-making processes.

All evaluation activities should strictly adhere to the principles outlined in SAMHSA's guidelines for cultural competence. This includes actively considering the potential for disparate outcomes among diverse populations united by characteristics such as geography, age, gender, racial/ethnic background, disability, health status, sexual orientation, and socio-economic status.

(H) ACTION/SUSTAINABILITY PLAN

SPF Step 4: IMPLEMENTATION (Action Plan); All SPF Steps (Sustainability)

The Implementation Plan, in section (G) above, serves as the **SPE Action Plan tool** that will guide this comprehensive strategic plan over the next five years.

Sustainability is woven through each step of the SPF and as such, has been addressed throughout the MA SPE development process. The intent of this section is to articulate how the BSAS Prevention Unit will ensure the continuation of effective policies, strategies, practices and infrastructure enhancements if/when both state and federal assistance is reduced or eliminated. This approach will guide BSAS in its ongoing efforts effectively address and sustain substance abuse prevention throughout the state.

Forethought to **sustainability was built in throughout the planning phase** and was a strong consideration in the selection of priority issues as well as **in the development of each set of goals and objectives**. Sustainability is an ongoing process that BSAS will continue to engage in while implementing the strategic plan and applying the SPF to ensure high quality prevention statewide and at the community level.
For each goal, conceptualization of sustainability has been at the fore from inception via the following process:
(1) Prioritizing strategies that are most likely to contribute to the desired outcomes and can be sustained;
(2) Examining current and considering potential future resources and funding sources that are or may become available to sustain the strategies;
(3) Identifying concrete sustainability action steps; and
(4) Brainstorming potential collaborators or stakeholders who can help support and promote sustainability efforts.

This Sustainability Plan is a natural extension of the Implementation Plan. As the goals, objectives, and outcomes identified in the Implementation Plan are realized, BSAS will simultaneously and continuously pursue strategies to continue the work with or without additional financial support. For each goal, and the associated high-level or "meta" strategies (listed below), we have identified and described specific sustainability strategies, along with the resources necessary and potential collaborators to support these efforts.

GOAL 1: Enhance the state's ability to track, monitor and report on prevention activities, substance abuse patterns, and emerging issues using existing and new data sources.
High-level meta-strategies:

- Develop and finalize an online reporting system for all BSAS funded and non-funded programs.
- Promote and increase data sharing by reinstituting the MEW and working in collaboration with the IAC.
- Expand the Bureau's capacity to store, organize, and analyze substance abuse prevention data.

- Collect data to help identify communities of high need and emerging issues.

Resources required:
Funding to complete online reporting system has been secured (through the Block Grant). System maintenance will be needed on an ongoing basis. Data sharing and collection of new data will require in-kind support from other DPH departments and other state agencies.

Sustainability Strategies:
BSAS is committed to maintain data systems as an integral part of the agency's overall infrastructure. BSAS is committed to ongoing community capacity building. BSAS Prevention team will work with other DPH departments and state agencies to gain support for data sharing and to pursue collection of new data.

Potential Collaborators:
BSAS will continue to access federal funding opportunities to support these objectives. The Prevention team will look to federal partners, such as SAMHSA, as well as the IAC and other state agencies to support sustainability strategies. The IAC will work with ongoing and new state agencies to identify staff and/or other resources to work with the MEW on data gathering and sharing.

GOAL 2: Enhance collaboration and coordination within and among state agencies and other stakeholders, including primary health care and mental/behavioral health care, to prevent/reduce substance abuse.
Meta-strategy:
- Inventory current substance abuse prevention efforts and funding streams.

Resources required:
Currently, support for these strategies is incorporated into multiple grants and dedicated in-kind resources at the department. Continued funding will be necessary until these efforts are systematized. IAC leadership will be crucial to sustaining and maintaining these efforts.

Sustainability strategies:
BSAS will continue to seek new funding opportunities to strengthen collaborations across state entities. The IAC will work with current and new member representatives from state agencies to institutionalize coordination of resources and efforts around substance abuse prevention.

Potential Collaborators:
Interagency Council involvement is a key piece to leveraging limited state dollars to impact the health of the Commonwealth.

GOAL 3: Prevent/Reduce substance abuse with a continued focus on underage drinking.
Meta-strategies:

- Identify, fund and provide technical assistance to Communities of Greatest Need as they apply an SPF process to select and implement evidence-based substance abuse/UAD prevention strategies.
- Align substance abuse/UAD prevention efforts across DPH departments and state agencies.
- Engage local, statewide and legislative champions to foster collaborative efforts to influence policy and practice changes that will support prevention of substance abuse/UAD.

Resources required:
Currently supported through block grants and in-kind support from other MDPH departments, these efforts will require continued funding and in-kind supports.

Sustainability strategies:
BSAS will work with IAC members to identify resources and will collaborate with IAC member agencies to acquire ongoing resources.

Potential Collaborators:
BSAS and the IAC will work with the MA Executive Office of Public Safety to identify needs. The legislative committee will continue to be informed and engaged through BSAS leadership, advocacy groups and local coalitions. Community coalitions will be supported to access local media and engage advocacy groups to raise awareness.

GOAL 4: Prevent/Reduce fatal and non-fatal opioid overdoses.
Meta-strategies:
- Identify, fund and provide technical assistance to Communities of Greatest Need as they apply the SPF process to select and implement evidence-based opioid overdose prevention strategies.
- Align opioid overdose prevention efforts across DPH departments and across state agencies.
- Engage local, statewide and legislative champions to foster collaborative efforts to influence policy and practice changes that will support prevention of opioid overdoses.

Resources required:
This work is currently supported by MDPH/BSAS. Block grant funds support TA and Training, a component of all community funding. Continued funding, as well as policy and practice changes, are required to further this work.

Sustainability strategies:
Apply for federal resources to maintain and expand community level opioid overdose prevention work. Continue to work towards institutionalizing opioid overdose prevention and intervention programs (e.g., needle exchange and Narcan work) through leveraged state

resources. Key constituencies, community coalitions and BSAS leadership will keep legislative champions informed and engaged.

Potential Collaborators:
BSAS will work with Medicaid to explore opportunities within health reform for additional support and continue to partner with SSRE to conduct evaluation. Key constituencies and community coalitions will keep legislative champions informed and engaged. Advocacy allies (i.e., MOAR) will continue to support understanding of issues at local and state levels.

(J) CULTURAL COMPETENCY

SPF Steps: ALL

Cultural competence is addressed throughout each step of the SPF process, as it was throughout our MA SPE process, to ensure creation of a culturally appropriate long-term strategy to meet the substance abuse prevention needs of the MA population, as well as to sustain policies, programs, and practices. Cultural competence will come into play as we adapt future RFPs to ensure, as appropriate, inclusion of Communities of High Need, including high-risk non-geographic populations such as Native American tribes, Military Families/Veterans and LGBTQ individuals. As this 5-year strategic prevention plan is operationalized, cultural competence will not only continue to be top of mind during resource allocation determinations, but will become an even more substantial factor in all facets of the state's approaches to substance abuse prevention.

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